MED - Medical Support Acute Retrospective Review Claims Selection

Purpose: Retrospective review is to identify and eliminate unreasonable, unnecessary and inappropriate care provided to Medicaid members. Claims will be extracted for a variety of reasons: 1) to monitor quality, necessity and appropriateness of services, 2) assess medically unnecessary admissions, 3) identify problems with premature discharges from the hospital, 4) Diagnosis Related Group (DRG) validation, 5) question quality of care 6) identify cases that exceed fixed DRG or costs or number of days for an average length of stay and 7) identify appropriate length of stay and level of care for swing beds. Quarterly reports are posted within 10 business days of the end of the reporting quarter and provide the outcomes of the reviews.

Identification of Roles:
Programmer - will query the data warehouse for the claims.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: A retrospective random sample, post discharge, approximately ten percent, will be selected for case review.

Step 2: The programmer will query the data warehouse (DW) for the claims and perform the selection.

a. Approximately 140 inpatient and 40 outpatient cases will be selected each month.

Step 3: A random sample of claims paid that includes inpatient, outpatient, swing beds and non-inpatient units will be selected for retrospective review.

Step 4: A sample of the previous month's claims, readmissions or transfer is pulled on the first and fifteenth business day of each month.

Business Rules for Selection of inpatient and outpatient 40:

a. Inpatient 140 claims randomly selected. The pull will occur approximately around the fifteenth of each month.
    1. Select up to 20 readmissions and transfers
        a. Maximum of 10 readmissions and 10 transfers
    2. Two cost outliers
    3. Two day outliers
    4. Maximum of 8 psychiatric claims
    5. Randomly select the rest to yield a total of 140
b. Outpatient 40 claims randomly selected. The pull will occur approximately around the first of each month.
    1. Select all OBSV- Intense >36 hours based on admit and discharge date
    2. Select the remaining records based on the following schema that repeats until there is a yield of 100:
        a. 306-307
        b. 271-273
        c. 251-255

d. 191-199
e. 191-200
f. 131-140
g. 111-124
h. NUTR-COUNS
i. SUB_ABUSE
j. Diabetes Education

c. The same member within the last 12 months will not be chosen if the following exist:
    1. Same first and last date of service
    2. Same provider
    3. Same type of selection
        a. Transfer
        b. Day outlier
        c. Cost outlier
        d. Readmission
        e. Random high
        f. Random low
        g. Swing beds

RFP Reference:
6.2.1.2 .

Interfaces:
MMIS
OnBase
MQUIDS

Attachments:
N/A

MED - Medical Support Acute Retrospective Review Requesting Medical Records

Purpose: The review assistant (RA) prepares merged data selection to create record requests and face sheets.

Identification of Roles:
Review Assistant (RA) – will prepare face sheets, selection list, and mail request for records.

Review Coordinator (RC) – will verify the requests for each provider.

Performance Standards: Performance standards are not specified for this procedure.

Path of Business Procedure:

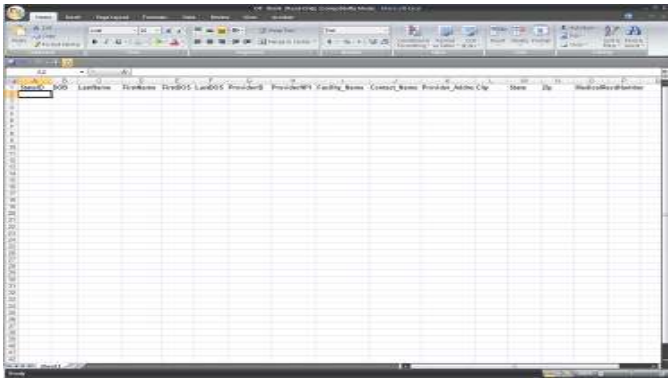
Step 1: The RA receives member selection list from programmer and saves it on the medical services:\Retro\Retro Selection.xls by date and year for inpatient or outpatient.

a. Once the data is saved, the RA will ensure there are no duplicate claims such as same member, same facility, and same dates of service.
b. The RA will send an e-mail to Program Integrity (PI) to make sure they have not already reviewed Transaction Control Number's (TCN) listed in spreadsheet from programmer.
c. Once the RA hears back from PI and none of the TCN's were reviewed, the RA will proceed with procedure. If TCN's were reviewed, the RA will delete them from the spreadsheet and then proceed with the request.

Step 2: The RA will sort the spreadsheet by facility name. Each facility pulled should have a contact person listed in the spreadsheet.

a. If there is not a contact person listed for a facility (the spreadsheet will say NULL), the RA will verify the address in MMIS for the facility.

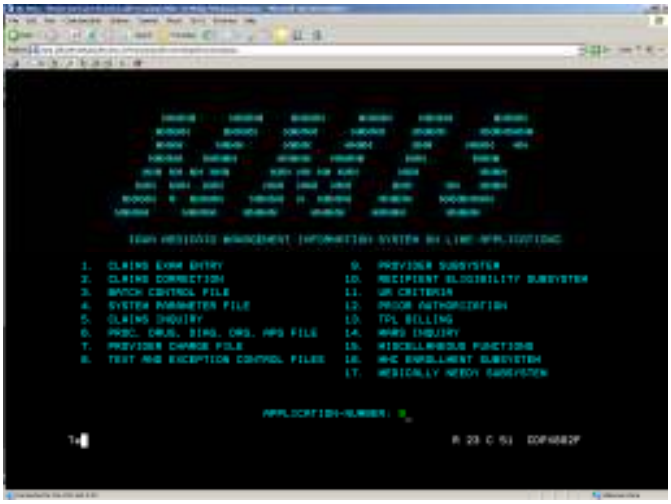
Step 3: The RA will access Medical Services:\Retro\Revised_hospital addresses spreadsheet and mail the request to the address listed.



Step 4: If there is not a contact liaison listed for the facility, the RA will log into Medicaid Management Information System (MMIS).

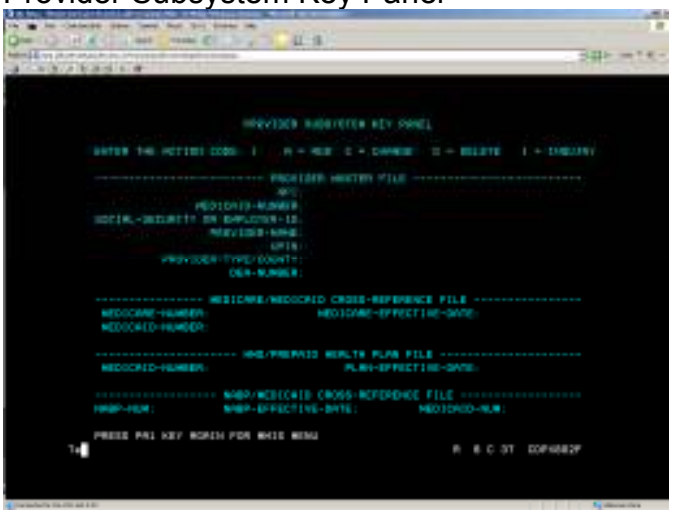
Step 5: The RA will access the provider subsystem by date entering nine as the application number.

MMIS Screen

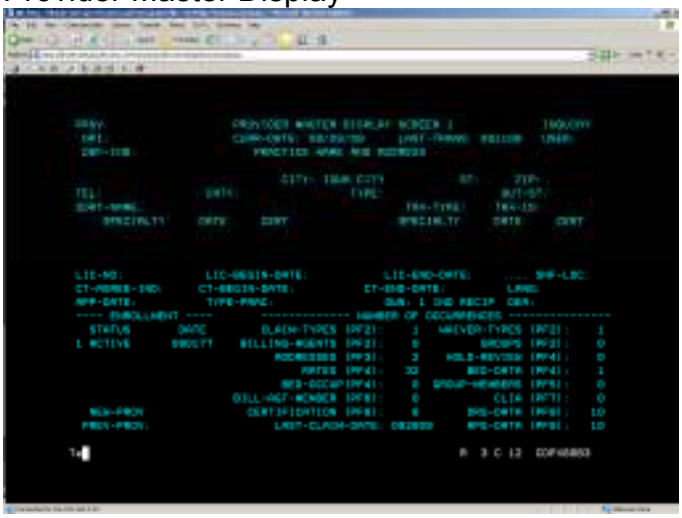


Step 6: The RA will enter action code I, and data enter the National Practitioner Identification (NPI) number for the provider and press enter.

Provider Subsystem Key Panel



Provider Master Display

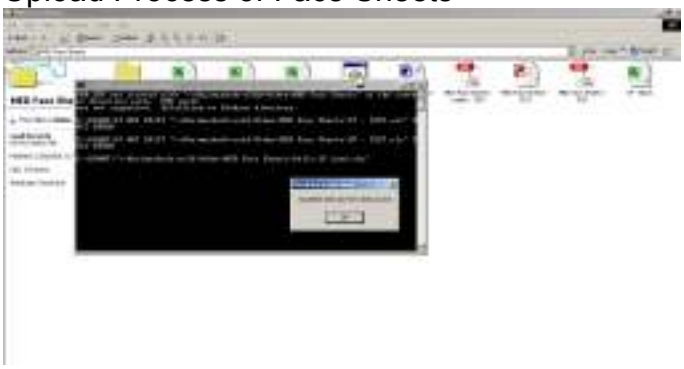


Step 7: The RA will contact the facility for contact information and update spreadsheet.
Step 8: The RA will highlight all data under the column headings.
Step 9: The RA will right click and select copy.
Step 10: The RA will close the spreadsheet. A pop-up box will appear asking to save the pasted information to the clipboard. The RA will select yes to paste this document into another program.
Step 11: The RA will access \\dhsimeobcp\COLD\Other\MED Face Sheets.
Step 12: The RA will select the inpatient (IP) or outpatient (OP) excel spreadsheet, the spreadsheet should be blank. If not, delete existing data except the column headings.
Step 13: The RA will copy the data into a spreadsheet.
Step 14: The RA will click save.
Step 15: The RA will double click on Load Records icon.

Load Records.bat

Step 16: A pop-up box will appear. The RA will click ok on Inpatient Data Saved to Source and Outpatient Data Saved to Source. The upload process is completed. The PDFs face sheets will be created.

Upload Process of Face Sheets



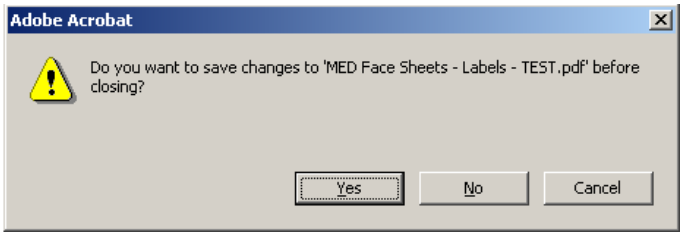
Step 17: To create face sheet, the RA will double click on Med Face Sheets. 

.

Step 18: To create the record request, the RA will double click on Med face Sheets Request. 

Step 19: To create labels, the RA will double click on 

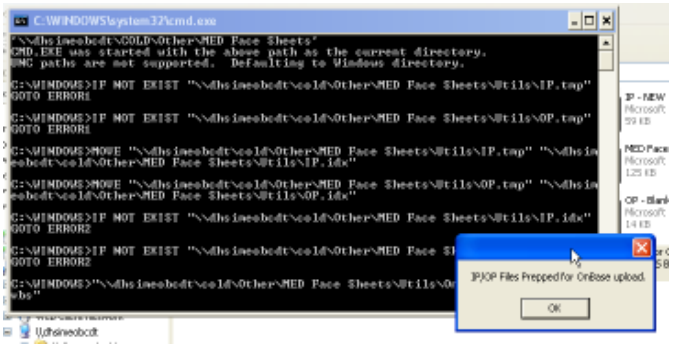
Step 20: The RA will click NO do not want to save chages after printing, face sheets, medical request, and labels.



Step 21: The RA will double click on Prep for OnBase icon.

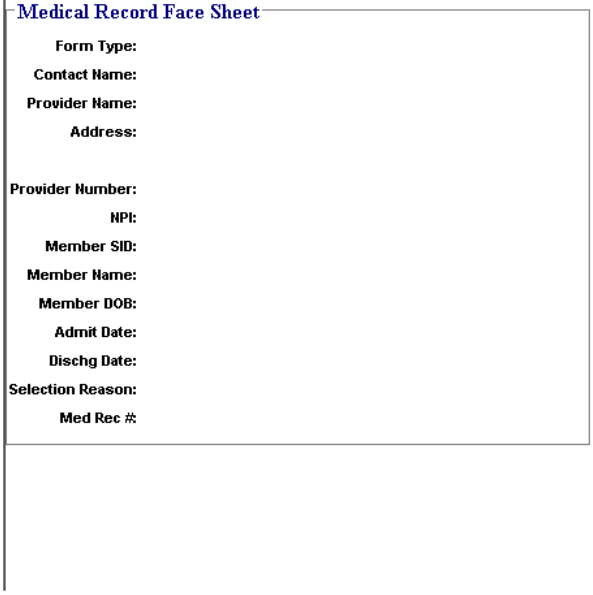

Prep For OnBase.bat

a. Files are prepped for OnBase upload will appear**.** The RA will click ok.



Step 22: The E-form is created and loaded into OnBase.

E-form


Medical Record Face Sheet

Form Type:
Contact Name:
Provider Name:
Address:

Provider Number:
NPI:
Member SID:
Member Name:
Member DOB:
Admit Date:
Dischg Date:
Selection Reason:
Med Rec #:

Step 23: The RA will mail the medical record face sheet and medical record request. All requests for the same facility will be sent in the same envelope.
Step 24: The RA affixes the label on the outside of the envelope and also affixes a label on the bottom left of the envelope that states Medical Record Request.

Forms/Reports:

Inpatient Medical Record Face Sheet

04/28/2009 10:05 FAX 5157251010 IME_ 001/001

Iowa Medicaid Enterprise - Medical Services
Inpatient Medical Record Face Sheet

04/28/2009

****Failure to submit the complete medical record, UB-04 and face sheet within the specified time frame will result in the issuance of a technical denial****

Clinic Rep
Test Facility/Clinic
123 Upper Way
Des Moines, IA 50314

Complete Medical Record is due 30 days from date printed on face sheet.
Outliers due 60 days from date printed on face sheet.

Please affix this medical record face sheet to the FRONT of each record requested and mail to:

Iowa Medicaid Enterprise
Attn: Acute Retrospective Review - Medical Services
P.O. Box 36478
Des Moines, IA 50315

Provider NPI:	2222222221	Member #:	7777777A
Member Name:	TESTER, SEVEN	Member DOB:	01/01/1900
Admit Date:	07/12/2007	Selection Reason:	Transfer
Dschg Date:	07/13/2007	Med Rec #:	357357357

A copy of the UB-04 MUST be sent with every complete medical record.
Please check the following for completed items:

- ☐ **UB-04**
- ☐ **Complete Medical Record**
- ☐ **Itemized Statement If Cost Outlier**

For Provider Use Only
TOTAL NUMBER OF PAGES: _____ POSTAGE PAID: _____

If you have any questions, please feel free to call toll free at 1-800-383-1173 or locally at 515-725-1008. If medical record is less than 30 pages, you may fax to: 515-725-1355, Attn: Acute Retrospective Review

470-4625 (Rev. 10/08)

PAGE 1/1 * RCVD AT 4/28/2009 10:03:28 AM [Central Daylight Time] * SVR:DHSIMEOBRFP/21 * DNIS:51355 * CSID:5157251010 * DURATION (mm-ss):00-42

Inpatient Medical Record Request

04/28/2009 10:08 FAX 5157251010 IME_ 001/001

Medical Record Request

☐ DHS Policy Staff	☒ Medical Services	
☐ Exception To Policy	☐ EPSDT	☐ Prior Authorization
☐ Member Services	☐ Lock-In	☐ Quality Of Care
☐ Pharmacy Services	☐ Long Term Care	☒ Retro Review
☐ Provider Services	☐ Pre-Pay	☐ Targeted Case Mgmt
☐ SURS	☐ Prior Authorization	☐ Waiver
☐ Audit And Rate Setting	☐ Pre-Pay	
☐ Other (Specify)		

04/27/2009

Medical Record requests are due 30 days from the above date.

Outlier Medical Record requests are due 60 days from the above date.

Clinic Rep
Test Facility/Clinic
123 Upper Way
Des Moines, IA 50314

Provider NPI: 2222222221

Iowa Medicaid Medical Record Request - INPATIENT SERVICES

Member Name:	Member ID:	Medical Record #:	Begin Date:	End Date:
TESTER, ONE	1111111A	123456789	07/12/2007	07/13/2007
TESTER, TEN	1234567A	357159654	07/12/2007	07/13/2007
TESTER, TWO	2222222A	987654321	07/12/2007	07/13/2007
TESTER, THREE	3333333A	321654987	07/12/2007	07/13/2007
TESTER, FOUR	4444444A	789456123	07/12/2007	07/13/2007
TESTER, FIVE	5555555A	159159159	07/12/2007	07/13/2007
TESTER, SIZ	6666666A	951951951	07/12/2007	07/13/2007
TESTER, SEVEN	7777777A	357357357	07/12/2007	07/13/2007
TESTER, EIGHT	8888888A	753753753	07/12/2007	07/13/2007
TESTER, NINE	9999999A	654159357	07/12/2007	07/13/2007

PAGE 1/1 * RCVD AT 4/28/2009 10:04:52 AM [Central Daylight Time] * SVR:DHSIMEOBRFP/18 * DNIS:51355 * CSID:5157251010 * DURATION (mm-ss):00-40

Outpatient Medical Record Face Sheet

04/28/2009 10:04 FAX 5157251010 IME_ 001/001

Iowa Medicaid Enterprise - Medical Services
Outpatient Medical Record Face Sheet

04/28/2009

****Failure to submit the complete medical record, UB-04 and face sheet within the specified time frame will result in the issuance of a technical denial****

Clinic Rep
Test Facility/Clinic
123 Upper Way
Des Moines, IA 50314

Complete Medical Record is due 30 days from date printed on face sheet.

Please affix this medical record face sheet to the FRONT of each record requested and mail to:

Iowa Medicaid Enterprise
Attn: Acute Retrospective Review - Medical Services
P.O. Box 36478
Des Moines, IA 50315

Provider NPI:	1111111111	Member #:	1111111A
Member Name:	TESTER, ONE	Member DOB:	01/01/1900
Admit Date:	03/18/2008		
Dschg Date:	03/18/2008	Med Rec #:	123456789

A copy of the UB-04 MUST be sent with every complete medical record.
Please check the following for completed items:

☐ **UB-04**
☐ **Complete Medical Record**

If you have any questions, please feel free to call toll free at 1-800-383-1173 or locally at 515-725-1008. If medical record is less than 30 pages, you may fax to: 515-725-1355, Attn: Acute Retrospective Review

470-4624 (Rev. 10/08)

PAGE 1/1 * RCVD AT 4/28/2009 10:02:38 AM [Central Daylight Time] * SVR:CHSIMEDSRFP/21 * DNIS:51355 * CSID:5157251010 * DURATION (mm-ss):00-30

Outpatient Medical Record Request

04/28/2009 10:06 FAX 5157251010 IME_ 001/001

Medical Record Request

☐ DHS Policy Staff	☒ Medical Services	
☐ Exception To Policy	☐ EPSDT	☐ Prior Authorization
☐ Member Services	☐ Lock-In	☐ Quality Of Care
☐ Pharmacy Services	☐ Long Term Care	☒ Retro Review
☐ Provider Services	☐ Pre-Pay	☐ Targeted Case Mgmt
☐ SURS	☐ Prior Authorization	☐ Waiver
☐ Audit And Rate Setting	☐ Pre-Pay	
☐ Other (Specify)		

04/27/2009

Medical Record requests are due 30 days from the above date.

Clinic Rep
Test Facility/Clinic
123 Upper Way
Des Moines, IA 50314

Provider NPI: 1111111111

Iowa Medicaid Medical Record Request - OUTPATIENT SERVICES

Member Name:	Member ID:	Medical Record #:	Begin Date:	End Date:
TESTER, ONE	1111111A	123456789	03/18/2008	03/18/2008

PAGE 1/1 * RCVD AT 4/28/2009 10:04:17 AM [Central Daylight Time] * SVR:DHSIMEOBRFP/10 * DNIS:51355 * CSID:5157251010 * DURATION (mm-ss):00-34

Forms/Reports:
N/A

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Review Logging Medical Records

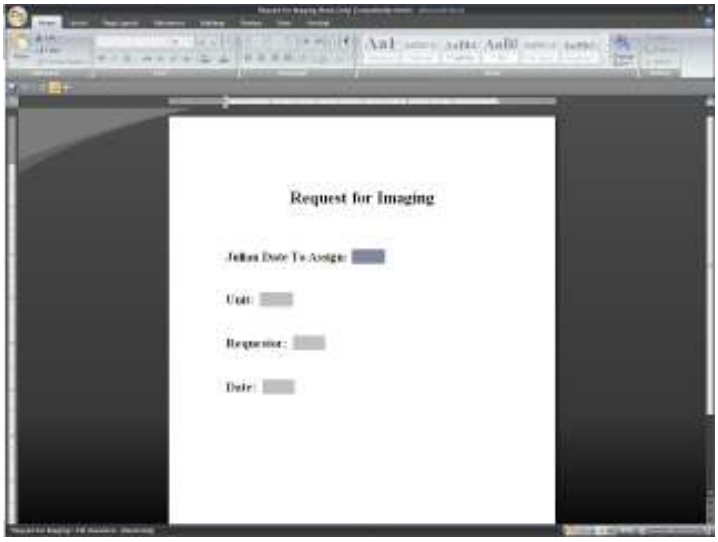
Purpose: Medical records are scanned into OnBase. Each record will be key-worded to serve as a permanent record in the system.

Identification of Roles:
Review Assistant (RA) – will enter keywords on all medical records received.

Review Coordinator (RC) – will received logged records through their assigned queues.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: Medical records will be received by fax or mail. Some records sent by United Parcel Service (UPS) or FedEx to Iowa Medicaid Enterprise (IME) are received by the receptionist.
Step 2: The receptionist will notify the retrospective review RA.
Step 3: The RA will complete a request for imaging form located on the IME universal/forms share drive.



Step 4: The RA will attach the request for imaging form to the medical records and route to the IME mailroom.
Step 5: The RA will complete the form with the requestor's name, unit, and date then will attach the request form to the medical records and route to the IME mailroom.
Step 6: The CORE staff will scan the records into OnBase.

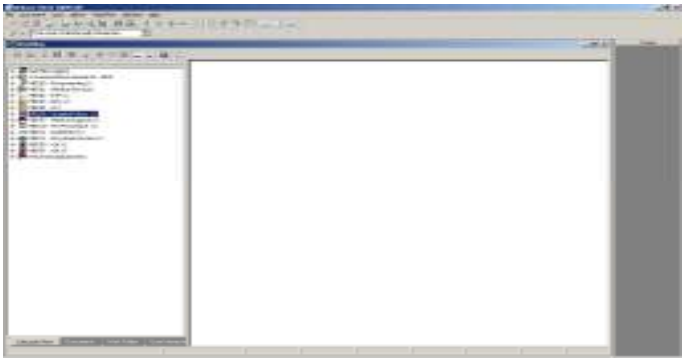
a. Once the hard copy is received in Medical Services, the RA will access MED05 Logging Queue.

Step 7: The RA logs into OnBase by entering user name and password.

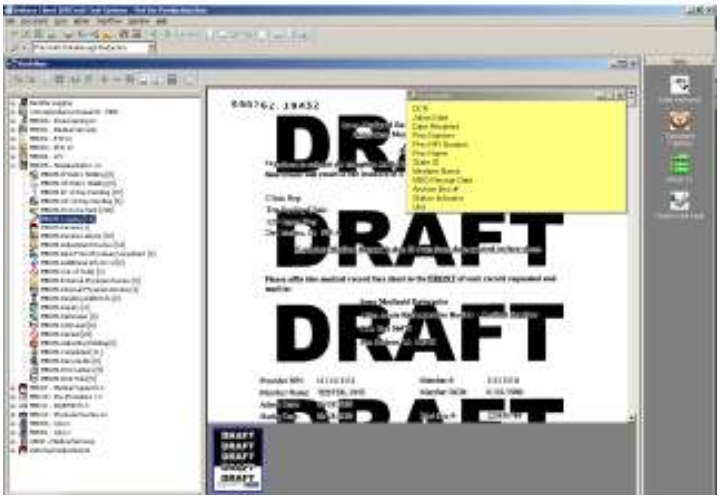
Step 8: The RA clicks on the workflow icon.
Step 9: The RA clicks on the lifecycle view tab.

a. Go to MED05 Hospital Retro Lifecycle.

Step 10: The RA clicks on + next to MED05 Hospital Retro Lifecycle.

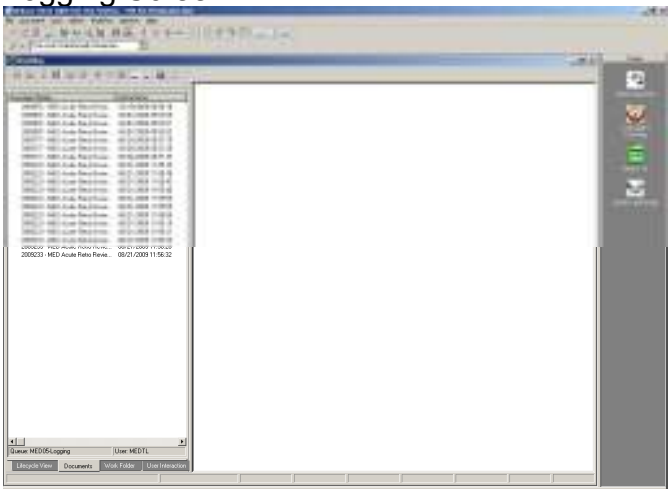


Step 11: The RA will click on MED05 Logging to bring up the medical record.



Step 12: The RA will click on the document.

Logging Screen



Step 13: If the medial record is received at the front desk and routed to the RA for imaging, the IME mailroom will hand deliver the records in hardcopy to the RA.

Step 14: If the medical record is faxed into OnBase, the RA will:

a. Print the medical record
b. Stamp the date in the upper left corner of the medical record
c. Double click on Enter Keywords icon on the right side of the screen. RA will data enter:
    1. NPI
    2. Member State Identification Number (SID)
    3. Dates of service
    4. Hard copy received date
        a. The date the mail room received the records
        b. If it is an inpatient record, the RA will data enter postage and pages information.
    5. Choose the appropriate RC from the drop down box
    6. Click save

Step 15: A box will appear showing "A matching MED Acute Retro Review Outbound form was found and removed from workflow". The RA will click ok.

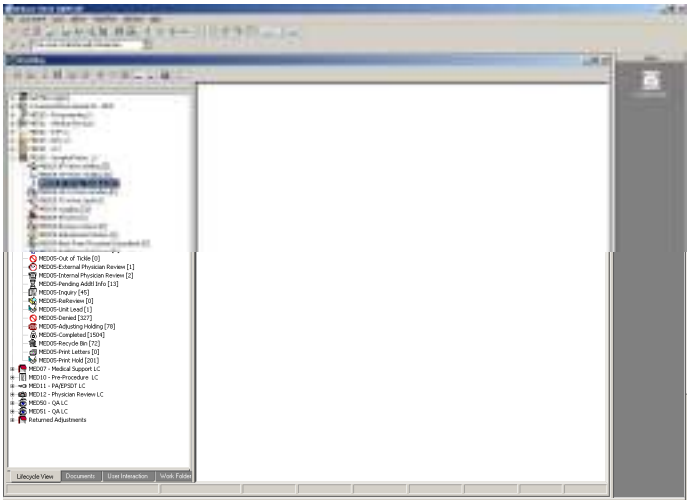
Step 16: Another box will appear asking, "Do you wish to send this to RC NAME or RC NAME's queue?" The RA will click yes.

Step 17: The medical record will then move to the RC review queue in OnBase.

RC Key Wording E-form

Step 18: If the medical records are not received within 20 days, it is moved to the 10 day pended queue.

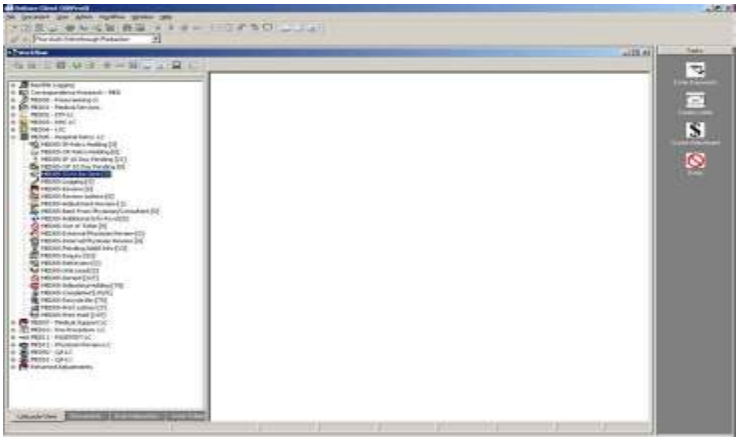
10 Day Pending Queue



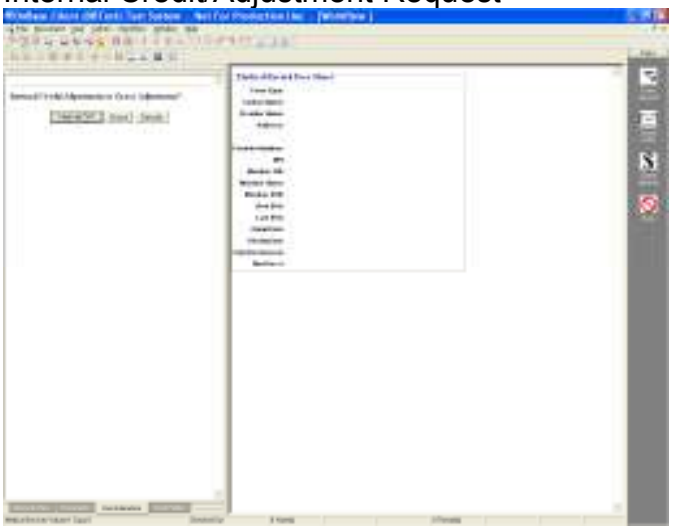
Step 19: If medical records are not received after 10 days, the e-form moves to the technical denial to be sent queue.

Step 20: The RA will generate a technical denial letter and an internal credit adjustment to pay claim at zero.

Technical Denial Queue



Internal Credit/Adjustment Request



Forms/Reports

Inpatient and Outpatient Reminder Letter DCN:

[Name]
[Address]
[City], [STATE] [Zip]

RE: [First Initial, Last Name]: ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On **,** Medical Services sent you a medical record request for the member identified above. If Medical Services does not receive a copy of the medical record including any additional information as requested in our letter, **30 days** from , Medical Services is required to deny payment for this admission

Please submit the requested information by faxing to 515-725-1355 or mail to:

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(9)

Technical Denial Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Your facility has not provided the **requested** for the above medical record.

Medicaid will not pay for the services due to failure to provide the complete medical record.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(24)

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Medical Records Review Overview

Purpose: Retrospective review of inpatient and outpatient services will be performed to monitor quality, medical necessity and appropriateness of services, and the accuracy of billing for which Medicaid payment was made.

Identification of Roles:
Review Assistant (RA) – will move medical records in OnBase to RC.

Review Coordinator (RC) – will utilize overview guidelines for conducting medical review.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: The RC will review a random sample of hospital inpatient and outpatient claims reimbursed under the Diagnostic Related Group (DRG) and Ambulatory Member Groups (APC) payment system.
Step 2: The random sample will be pulled by the programmer and provided to the RA to do medical record requests on the first and fifteenth business day of every month. The sample of claims is for the previous month's claims, readmissions or transfers based on certain DRGs, procedures, and APC codes.
Step 3: The provider will supply a copy of the medical record, a copy of the UB-04 bill, and the itemized statement, if needed, within 30 days (60 days for outliers) following the date of the request.
Step 4: The 30 day time period for review will start when the complete medical record is received. If the hospital fails to meet the timeline of 30 days, the RA will issue a technical denial (TD).
Step 5: A case may have been previously technically denied and an adjustment submitted to take back the reimbursement for the claim because medical records were not submitted timely. If the facility later sends the records within 365 days from the TD date the RC will then send a TD reversal letter notifying the provider that the review will now be processed. The RC will have 30 calendar days in which to complete the review of those medical records from the date of receipt of the record.
Step 6: Review information will be documented in the workflow process management system (MQUIDS) by the RC.
Step 7: If the RC has concerns regarding the case for medical necessity, appropriateness of outpatient setting or validity of the inpatient International Statistical Classification of Diseases and Related Health Problems (ICD-9-CM) diagnostic or procedural codes, the case is referred for physician review (PR).
Step 8: If the RC does not have concerns regarding either utilization, quality, or as result of DRG validation, the review will be completed within 30 calendar days.
Step 9: If the medical record was received timely, the following five functions for inpatient review are to:

1. Determine if the admission and services were medically necessary;
2. Identify problems with premature discharges;
3. Determine if the diagnostic and procedure information that led to the DRG; can be substantiated in the medical record;
4. Identify quality of care issues; and
5. Determine medical necessity of invasive procedures that affect the DRG
    a. Cases not meeting criteria for the five functions or cases requiring substantiation of days for medical necessity will be referred to a PR.

Step 10: If the RC notes the medical record is incomplete, a Request for Additional Information letter is sent the facility. This letter indicates the facility has an additional 15 days from the date on the letter to submit the requested documentation prior to Medical Services proceeding with a technical denial.

1. If the additional documentation is received within 15 days, Medical Services will have 30 days from the date of receipt of complete documentation to perform the five review functions as per policy.

Forms/Reports:

Inpatient and Outpatient Additional Documentation Request Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Appropriate documentation enables physicians and other health care professionals to plan and evaluate the member's care and promotes communication and continuity of care. For medical reviewers, appropriate documentation provides a complete depiction of the events during diagnosis and treatment and enhances and speeds the review process.

During the course of reviewing the above medical record, the reviewer was unable to proceed due to the following missing information:

Your written response must be received within **15 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns. Submitting the requested information within the specified time frame will prevent the issuance of a technical denial. Submit your request with this letter or a copy of it in writing by faxing to 515-725-1355 or mail to:

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(12)

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Inpatient Admission Review

Purpose: Admission review will be conducted on all cases identified to determine whether the admission was medically necessary and services delivered were in the most appropriate setting. Admission review is comprised of determining medical necessity for a hospital admission utilizing Acute Milliman Criteria.

Identification of Roles:
Review Assistant (RA) – will print and mail denial letters

Review Coordinator (RC) – will review medical records based on specific review guidelines and generate appropriate letter.

Medicaid Medical Director (MMD) – will be consulted as needed.

Performance Standards:
Performance standards are not specified for this procedure.

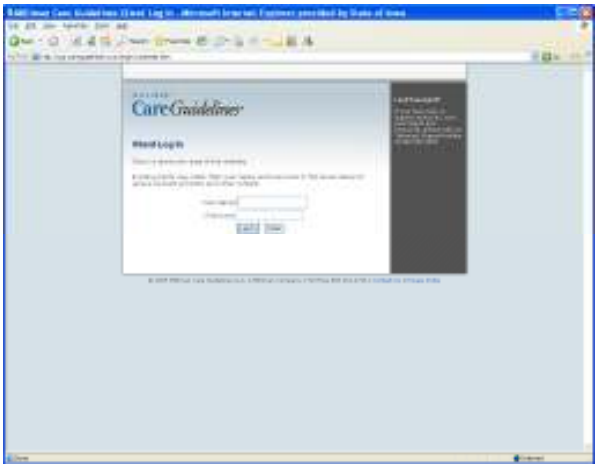
Path of Business Procedure:
Step 1: If the RC has concerns regarding services found to be unnecessary or provided in an inappropriate setting, quality of care, or the validity of the ICD-9-CM diagnostic or procedural codes, the case is referred for PR.

a. If the PR confirms the concerns, the provider will be given the opportunity to submit additional information. Only the information necessary to approve the procedure will be requested and reviewed.

Step 2: If the provider does not send additional information, the services will be denied.
Step 3: The RA and/or RC will review submitted documentation to ensure that the request is complete. RA and/or RC will complete a request for additional information if needed. RAs do not make clinical decisions or complete clinical interpretation of information.
Step 4: The RC will utilize Milliman Criteria to validate the medical necessity of the admission and the appropriate days for the diagnosis and condition of the member at any time during the stay.
Step 5: The RC accesses the Milliman criteria by going into the website http://cgi.careguidelines.com/logoff.htm.
Step 6: The RC clicks on the “To log in, click here” option.

Step 7: The RC enters the user name “ifmccriteria” and password “share”.

Milliman Care Guidelines Log-in Screen

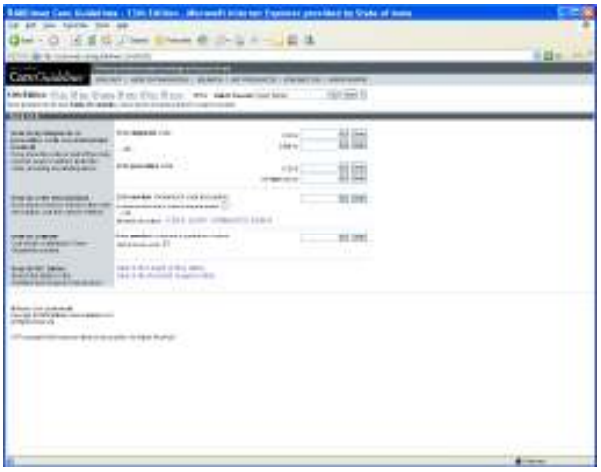


Step 8: The RC selects the applicable product i.e. ambulatory care or inpatient care.

Milliman Product Screen

Step 9: The RC enters the applicable condition, i.e., heart failure in the quick search or the ICD-9 code to search the criteria.

Milliman Search Screen



Step 10: The RC selects the appropriate guideline i.e. inpatient or observation criteria.
Step 11: The RC clicks on “clinical indications for admission to inpatient/observation care”.

Clinical Indication for Admission to Inpatient Care

Step 12: The RC determines if the case meets Milliman criteria.

a. If the case meets Milliman criteria, the RC data enters the correct criteria number located below the criteria name e.g. M-190 in MQUIDS.

Results Screen

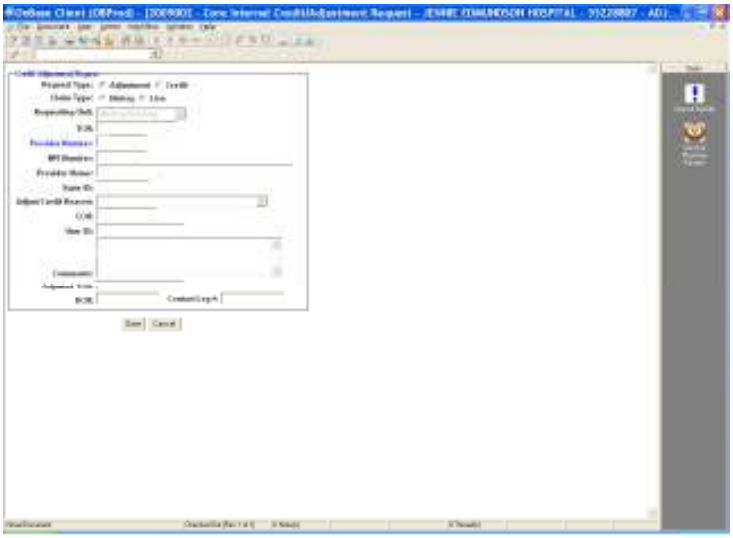
Step 13: If the case does not meet Milliman criteria, the RC will refer to PR.

Step 14: If the admission is not medically necessary or appropriate i.e., no inpatient hospital care was needed or delivered during the stay, the admission will be denied by PR.
Step 15: If services are found to be unnecessary or provided in an inappropriate setting, inappropriate billing occurred, or quality of care services are questioned**, the admission will be denied by PR.**
Step 16: If the admission / services are determined not medically necessary or appropriate the RC will send a letter to the provider of the discrepancy noted. The provider will be given the opportunity to submit additional information.

Credit Adjustment
Step 1: The RC will send a credit/adjustment form to CORE through workflow in OnBase if a final review results in payment consequences to the provider.
Step 2: The form must explain in detail the reason for the credit or adjustment. It is not necessary to submit a copy of the claim or a screen shot from MMIS.
Step 3: The RC will complete the information on form and click on submit.

a. If the CORE unit requires additional information, the form will be returned to the RC through OnBase.

OnBase Credit/Adjustment Request



Critical Access Hospital Review

Step 1: Critical Access Hospitals (CAHs) are defined as a rural facility with no more than 15 acute care beds, or no more than 25 beds used interchangeably for acute or skilled nursing facility level of care (LOC). A CAH must be located more than 35 miles from another hospital, must be able to provide 24-hour emergency care services, and agree to keep each member for no longer than an average of 96 hours.
Step 2: CAHs will be included in the random sample of retrospective non-outlier review. Because CAH length of stay is based on an average not to exceed 96 hours, the RC will not complete a review of the length of stay.
Step 3: The review process will include the same functions as the retrospective review process, DRG validation, admission review, quality review, invasive procedure review, and discharge review.
Step 4: The RC will follow the same procedure as the retrospective review process to send adverse determinations of medical necessity, quality concerns, and/or DRG validation to involved provider(s) and members with traditional Medicaid coverage.

Validate Discharge Disposition

Step 1: Validation includes confirmation of the correct discharge status.
a. If the RC finds an error in the discharge status, record the correct disposition.
b. Include in the rationale a description of the coding and disposition change.

Step 2: If PR is required, the RC will click on Add New Review and select the PR name from the drop down box.
a. This entry will display on the screen.

Step 3: If the PR denies services, the RC will complete a letter in OnBase with physician's rationale.
Step 4: The RA will mail out an initial inquiry letter to the attending physician and the hospital.

Forms/Reports:

Inpatient and Outpatient Initial Billing Error letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. Medical Services is also required to monitor the accuracy of billing for services provided to Medicaid members.

The medical record submitted for review, reflects a variance that may affect your facility's reimbursement for services based on the coverage and billing guidelines found in Chapters E & F of the Medicaid Hospital Services Provider Manual. Based upon the review of the medical record, the following pending billing discrepancies have been identified:

Medical Services is providing you an opportunity to discuss this medical record. To assure that the reviewer considers any verbal information not supported by the medical record, please submit a copy of your addendum to the medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination.

Your response to this is important for providing clarification and possible resolution of the identified concerns. Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

To assure that the reviewer considers any verbal information not supported by the medical record, please submit a copy of your addendum to the medical record.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(16)

Inpatient and Outpatient Final Billing Error letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member:[First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Medical Services determination is based on the following:

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. Your written response must be received within **60 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to:

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(13)

Inpatient and Outpatient Initial Quality Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer , has raised some questions regarding the .

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received within 30 days of the date of this inquiry, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

The information in this letter is confidential and may be redisclosed only in accordance with federal regulations found in 42 CFR 476.107-108. The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(18)

Inpatient and Outpatient Final Quality Letter

DCN:

[Name]
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services reviews **inpatient** services provided to Iowa Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The following concern has been upheld:

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. You must submit your request for a re-review in writing within **60 days** from the receipt of this notice in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(15)

cc:

Inpatient and Outpatient Initial Utilization Review Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer , has raised some questions regarding the .

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received in Medical Services within **30 days** of the date of this letter, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(19)

cc:

Inpatient and Outpatient Final Utilization Review Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services reviews **inpatient** services provided to Iowa Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The following concern has been upheld:

If you disagree with Medical Services determination, you may request an appeal. You must submit your request in writing within **30 days** from the date of this letter to the Department of Human Services, Appeals Section, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(15)

Attachment: Denial Letter & Appeal Rights

cc:

You Have the Right to Appeal

What is an appeal?

An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?

Filing an appeal is easy. You can appeal in person, by telephone or in writing for Food Assistance or Medicaid. You must appeal in writing for all other programs. To appeal in writing, do **one** of the following:

- Complete an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

For Food Assistance or Medicaid, you have 90 calendar days to file an appeal from the date of a decision. For all other programs, you must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice or
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Inpatient and Outpatient Denial to Member Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

In the course of performing the required review, Medical Services physician reviewers were not able to approve the medical necessity of this **hospital admission** . Your physician and the hospital representative were notified of the pending decision and were provided an opportunity to respond prior to this final determination.

Medical Services has determined that you did not know that the services denied were not covered under Medicaid. The Medicaid program will not pay the hospital for the denied services because the hospital knew or should have known that the services were not covered under Medicaid. You are responsible only for payment of convenience services and items normally not covered by Medicaid, or through spend-down payments under the Medically Needy Program, if applicable. If you have paid the hospital for any of the denied services other than those mentioned above, arrangements could be made to pay you back. Please contact your county DHS office for assistance.

Medical Services determination is based on the following:

If you disagree with Medical Services determination, you may request an appeal. You must submit your request in writing within 30 days from the date of the final denial letter to the following address: Department of Human Services, Appeals Section, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

This action is taken in accordance with 441 Iowa Administrative Code 79.9(2). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(17)

Attachment: Appeal Rights

cc:

MED - Medical Support Acute Retrospective Inpatient Quality of Care Review

Purpose: Cases will be reviewed to determine that care provided meets acceptable standards of medical care. Quality of Care (QOC) review is handled in a manner similar to Medicare review. That is, any case failing a generic quality screen, discharge screen, or any case where the quality of care delivered is questioned, will be referred to a PR in writing.

Identification of Roles:
Review Assistant (RA) – will access letters in OnBase and mail.

Review Coordinator (RC) – will open a case once medical records are received and complete a review based on specific review guidelines.

Medicaid Medical Director (MMD) – will be consulted as needed

Performance Standards:

- Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: Any case failing a quality indicator will be referred to PR.
Step 2: The physician and facility will be notified in writing of the concern.
a. There is a 30 day response time frame to respond.
Step 3: Cases with substantial violations may be included in any sanction activity initiated to support a pattern of substantial violations in relationship to Medicare cases that have been categorized as gross and flagrant and/or substantial. Suspicious cases will be referred to DHS for additional scrutinization and for them to determine if they case should be forwarded to CMS.
Step 4: The deciding factor for using the psychiatric generic quality indicators in the inpatient setting is the psychiatric diagnosis codes.
a. The attending physician need not be a psychiatrist for the indicators to apply.
Step 5: The RC will refer it to the PR if a case fails a Generic Quality Screen (GQS), discharge screen or invasive procedure medical necessity and quality of care is questioned, If there is a referral for a GQS failure, the PR will be required to complete the physician review form/rationale.
Step 6: The manager will notify DHS of any Medicaid quality of care cases determined to be gross and flagrant.
Step 7: The quality review process will include the same functions: DRG validation, admission review, quality review, invasive procedure review, and discharge review.

Forms/Reports:

Medical Quality Indicators

1a Adequate discharge planning_____
2a BP stable 24 hours before DC_____
2b Temperature not >101 oral for 24 hours_____
2c Pulse not <50 or >120 within 24 hours_____
2d Abnormal tests/procedures addressed or resolved_____
2e IV fluids or drugs after midnight on day of discharge_____
2f Purulent/bloody drainage within 24 hours of discharge_____
3a Death during/following surgery_____
3b Death with 24 hours of transfer out of ICU_____
3c Other unexpected death_____
4a Infectious disease and blood cultures addressed (bacteremia)_____
5a Unscheduled return to surgery_____
6a Unplanned surgery – caused by error during / prior to surgery_____
6b Complication of anesthesia_____
6c Fall-appropriate assessment / service_____
6d Transfusion error or reaction_____
6e Hospital acquired decubitus or deterioration of decubitus_____
6f Med error or drug reation addressed_____
6g Care or lack of care result in complications_____

Psychiatric Quality Indicators*

1a Inadequate psychiatric assessment_____
2a Adequate treatment planning_____
3a Evaluation to identify change in status_____
4a Adequate / appropriate use of medications_____
4b Medications monitored_____
4c. Adverse drug reaction or medication error with harm_____
5a Harm / trauma suffered in hospital - suicide or self-injury_____
5b Fall - appropriate assessment / services_____
5c Seizure addressed / treated_____
5d Loss of consciousness addressed / treated_____
5e Other serious injury or complication addressed_____
6a Restraints appropriate use_____
6b Restraint-physical or mechanical safe_____
7a Inappropriate use of seclusion_____
7b Seclusion appropriate_____
8a ECT appropriate_____
8b ECT safe_____
9a Discharge planning appropriate_____

*All deaths in the psych unit require PR.

Inpatient and Outpatient Initial Quality Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer , has raised some questions regarding the .

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received within 30 days of the date of this inquiry, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

The information in this letter is confidential and may be redisclosed only in accordance with federal regulations found in 42 CFR 476.107-108. The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(18)

Inpatient and Outpatient Final Quality Letter

[Name]
[Address]
[City], [STATE] [Zip]

DCN:

RE: Member: [First Initial, Last Name]
Dates of Service: -
Hospital:

ID#:
DOB: [MM/DD]

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services reviews **inpatient** services provided to Iowa Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The following concern has been upheld:

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. You must submit your request for a re-review in writing within **60 days** from the receipt of this notice in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(15)

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Review Inpatient Diagnosis/DRG Validation

Purpose: Hospitals are reimbursed based on a member's diagnosis and procedures performed during the hospitalization. DRG validation will be conducted to determine if the diagnostic and procedure information that led to the DRG assignment is substantiated by documentation in the medical record and matches the physician's discharge information. DRG validation will be conducted on every Prospective Payment System (PPS) case identified for review. Medical Services reviewers will utilize their knowledge of coding guidelines and related resources to perform this function.

Identification of Roles:
Review Assistant (RA) – will access letters in OnBase and mail.

Review Coordinator (RC) – will open a review case within 30 days of receipt of records, conduct review and determine appropriate billing of DRG.

Medicaid Medical Director (MMD) – will be consulted as needed

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: The RC will review the member's entire medical record to ensure the principal diagnosis is substantiated by tests, x-rays, history, and/or physician documentation.
a. The principal diagnosis is defined as "the condition established after study to be chiefly responsible for causing the admission of the member to the hospital for care."
Step 2: The principal diagnosis is the actual reason the member was hospitalized.
Step 3: If there is more than one reason equally responsible for the admission, the hospital has the option of choosing the diagnosis which provides the maximum reimbursement.
Step 4: When outpatient services are provided prior to an inpatient admission, the principal diagnosis in these cases is the reason the member was admitted to the hospital and not the reason the member received outpatient services.
Step 5: The RC will thoroughly review the record for all secondary diagnoses, co-morbid conditions and complications, and the conditions that affect the treatment the member received or the length of stay.
Step 6: Hospitals may report more than one secondary diagnosis, but are not required to do so.
Step 7: Diagnoses that affect the DRG assignment take precedence and at least one must be reported on the claim form.
a. The physician must attest to all secondary diagnoses reported on the claim form, but is not required to attest to any not reported.

Step 8: When there is more than one secondary diagnosis but the hospital has reported only one, the RC must make certain the secondary diagnosis that will affect the DRG, is reported.

a. All old diagnoses that do not affect this current admission will be omitted.

Step 9: RC should confirm that there are no omissions that could influence payment.

Step 10: A provider can receive inappropriate level of reimbursement through the reported diagnostic and procedure codes on the billing form examples are:

a. Incorrectly designating the principal diagnosis (reason for admission) by listing a secondary diagnosis as the principal diagnosis
b. Using a code for closely related, but incorrect, diagnoses
c. Reporting and coding diagnoses that the member does not have
d. Coding procedure that was not performed
e. Failure to report a secondary diagnosis (sometimes this results in a higher reimbursement)
f. Failure to report a procedure
g. Miscoding a procedure
h. Using a vague, general code to describe a diagnosis when information is available to code more exactly
i. When a principal diagnosis, as listed by the attending physician requires more than one code, disregarding coding rules and ordering the codes incorrectly (in essence, the code is designating an incorrect principal diagnosis).

Step 11: The RC will determine if the operative procedures are substantiated in the medical record by physician documentation and/or a pathology report.

a. Substantiation of significant operating room procedures should not be based solely on a discharge summary.
b. Review operative reports, pathology reports, etc., to determine if procedures were performed which were not reported and have precedence over those reported.

Step 12: The principal diagnosis as identified by the physician must be the principal diagnosis reported on the claim form.

Step 13: The principal diagnosis must be coded to the highest level of specificity, e.g., signs and symptoms may not be used as the principal diagnosis when the underlying cause of the member's condition is known.

Step 14: When no co-morbid condition, complication or secondary diagnosis which affects DRG assignment is shown on the bill, the medical record indicates the presence of at least one of these conditions, insert a new code.

Step 15: The secondary diagnoses identified should represent diagnoses that have the potential for significantly complicating the management of member care and increasing the risk of an adverse outcome.

Step 16: The principal procedure should be listed on the claim form and if there are more procedures performed that can be listed, validate the procedures attested to and reported on the claim are accurate and the principal procedure is shown. Principal procedures should be identified according to:

a. Procedure performed for definitive treatment rather than for diagnostic or exploratory purposes and most related to the principal diagnosis
b. Procedure performed for diagnostic or exploratory purposes and most related to the principal diagnosis

c. Procedure performed for definitive treatment and related to a secondary diagnosis
d. Procedure performed for diagnostic or exploratory purposes and related to a secondary diagnosis

Step 17: When the principal procedure is not shown on the claim, insert the new code.

Step 18: Physician review is required for any questions concerning medical judgment. A DRG change is only made after consultation with a PR.

a. The PR will indicate if the diagnoses and/or procedures are substantiated and provide rationale for the decision.
b. A physician may substitute a diagnosis based upon clinical signs and symptoms.
    1. Care must be taken not only to solidly support the diagnoses determined appropriate, but indicate why the original diagnoses were not valid.

Step 19: If the PR determines that the diagnoses and/or procedures were not substantiated, the physician must identify which diagnoses are and clearly identify the principal diagnosis.

Step 20: When changes in diagnosis or procedures occur, clearly write all diagnoses and procedures with appropriate ICD-9-CM codes for the DRG changes. Use the verbiage written by the attending physician on the medical record.

Step 21: Following review, when there is a change to the narrative description by the attending physician; notify the physician and the hospital only if the DRG has changed.

Step 22: The RC will notify the physician and hospital of any impending DRG changes and the provider is given an opportunity to submit additional information prior to the final review determination.

Step 23: The RC will access Credit/Adjustment form through document retrieval in OnBase.

Forms/Reports:

Inpatient Initial DRG Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member:[First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews inpatient hospital services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Medical Services is required to perform diagnostic related group (DRG) and disposition code validation on all medical records selected for review. This review is performed to ensure that the codes reported by the facility, which resulted in the DRG group assignment match the documentation in the medical record.

The episode of care referenced above has been reviewed. Based on a review of the medical record, Medical Services has determined that:

The hospital submitted the following codes and narrative description:

Diagnoses Description	**Diagnoses Codes**
1.	
2.	
3.	
4.	
5.	

Procedure Description	**Procedure Codes**
1.	
2.	

Potential coding change(s) and narrative description are:

Diagnoses Description	**Diagnoses Codes**
1.	
2.	
3.	
4.	
5.	

Procedure Description	**Procedure Codes**
1.	
2.	
3.	

This potentially would result in a change in the DRG assignment from **(billed DRG)** to **(new DRG).**

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

You may submit additional written information within 30 calendar days from the date of this inquiry by faxing to (515) 725-1355 or mail to:

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

Your response to this is important for providing clarification and possible resolution of the identified concerns. If the response is not received within **30 days** of the date of this inquiry, the final determination regarding the concerns raised in this letter will be made based on the information available in the medical record.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(8)
cc:

Inpatient Final DRG Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews inpatient services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Medical Services is required to perform diagnostic related group (DRG), and disposition code validation on all medical records selected for review. This review is performed to ensure that the codes reported by the facility, which resulted in the DRG group assignment match the documentation in the medical record.

Medical Services previously reviewed the episode of care referenced above. An opportunity to discuss this case was given to the facility and the physician.

Therefore, the claim will be denied and a new claim with updated DRG will need to be submitted.

The hospital submitted the following codes and narrative description:

Diagnoses Description	**Diagnoses Codes**
1.	

Procedure Description	**Procedure Codes**
1.	

Coding change(s) and narrative descriptions are:

Diagnoses Description	**Diagnoses Codes**
1.	

Procedure Description	**Procedure Codes**
1.	

This has resulted in a change in the DRG assignment from **(billed DRG)** to **(new DRG).**

After a review of the medical record, and/or review of any additional information submitted**,**
Medical Services determined that:

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **60 days** from the date of this letter by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(4)

Inpatient Initial Disposition Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: {First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:
Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews inpatient hospital services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Medical Services is required to perform diagnostic related group (DRG) and disposition code validation on all medical records selected for review. This review is performed to ensure that the codes reported by the facility, which resulted in the DRG group assignment match the documentation in the medical record.

The episode of care referenced above has been reviewed. Based on a review of the medical record, Medical Services has determined that:

Billed Disposition:
New Disposition:

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

You may submit additional written information within 30 calendar days from the date of this inquiry by faxing to (515) 725-1355 or mail to:

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

Your response to this is important for providing clarification and possible resolution of the identified concerns. If the response is not received within **30 days** of the date of this inquiry, the final determination regarding the concerns raised in this letter will be made based on the information available in the medical record.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(7)
cc:

Inpatient Final Disposition Letter

[Name] [First Initial, Last Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews inpatient services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Medical Services is required to perform diagnostic related group (DRG), and disposition code validation on all medical records selected for review. This review is performed to ensure that the codes reported by the facility, which resulted in the DRG group assignment match the documentation in the medical record.

Medical Services previously reviewed the episode of care referenced above. An opportunity to discuss this case was given to the facility and the physician.

Medical Services has determined that the admission was medically necessary and appropriate. However, based on a review of the medical record and any other information available, Medical Services is proceeding with the change in the disposition code.

Billed Disposition: :
New Disposition: :

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **60 days** from the date of this letter by faxing to 515-725-1355 or mail to:

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(3)
cc:

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Inpatient Cost/Day Outlier Review

Purpose: Inpatient Cost/Day Outliers outliers will be identified for cases in which the number of days in a stay exceeds the average length of stay by a fixed number of days or a standard deviation of the average length of stay. Inpatient Cost outliers, are those cases whose costs exceed a fixed multiple of the applicable DRG rate or exceed a fixed dollar amount, whichever is greater. These thresholds are predetermined by DHS.

IME will review a random sample of all outlier claims from all Iowa and bordering state hospitals.

Identification of Roles:
Review Assistant (RA) – will retrieve medical records, distribute to RC and mail letters.

Review Coordinator (RC) – will open a review case within 30 days of receipt of the records and review medical records for cost and day outliers.

Medicaid Medical Director (MMD) – will be consulted as needed

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: Cost outliers will be processed retrospectively. The hospital must supply the medical record, the remittance statement, and an itemized bill within 60 days of receipt of the outlier medical record request, or outlier payment will be recouped and forfeited.
Step 2: If the admission was not medically necessary or appropriate i.e., no covered inpatient hospital care was needed or delivered during the stay, the admission and the outlier costs will be denied.
Step 3: If any costs totaling greater than $500 are denied, a pre-denial notification letter will be sent to the physician and hospital, allowing a 30 day comment period prior to issuance of the denial notice. The reviewing physician's comments will be included in the letter to the physician.
Step 4: If a response is received from the provider, a re-review will be completed.
Step 5: If the reviewing physician upholds the initial denial decision, a denial notice will be issued to the member (day outlier only), hospital and physician. Third level reviews are available for denials involving medical necessity determinations.

<u>Technical Review</u>
Step 1: Prior to obtaining physician review, the RC will perform a technical review. Using the medical record and the itemized bill, a detailed analysis will be conducted to ensure that all services billed were:

a. Not duplicates;
b. Actually rendered; and
c. Ordered by a physician

Step 2: To improve the timeliness of the cost outlier review, the following steps will be implemented in regard to the technical analysis and physician review:

a. Validate that the medical record, review work sheet, and bill are for correct admit.
b. Verify that the bill total equals the total on review work sheet. Note any questionable areas on the work sheet and focus review on those areas.
c. Scan the bill for obvious errors such as:
    1. Key punch errors e.g., l,500.00 vs. l5.00
    2. Billing an item that should be charged on a daily rate, rather than on an hourly basis, (e.g., respirator)
    3. Non-covered items (professional fee, personal convenience items)unidentifiable/unspecified charges
d. Verify room and board charges by:
    1. Checking orders for appropriate room bill
    2. Checking for duplicate billing
e. Verify room and board charges by:
    1. Scanning for supplies that might be inappropriate for the member's condition or may be billed in error.
    2. Scanning pharmacy list and verify that costly medications e.g., albumin - TPN are ordered and received.

Step 3: If several areas have excessive charges, review first or second day, compare billed items with orders and number rendered. If there are excessive numbers of EKG's, labs, physical therapy, X-rays, etc., compare number billed with number ordered and with number rendered.

Step 4: The RC will record discrepancies in the notes section of MQUIDS.

Step 5: All medical orders must be in writing and signed by a physician. Telephone orders must be signed or initialed by the physician as soon as possible. All physician orders must be signed prior to sending the medical record for review.

Step 6: The case is referred to a PR when the RC questions the medical necessity for certain items or services; e.g., ICU vs. regular room, initial need for and/or continued need for specialized services (PT, OT, and RT).

Step 7: The reviewing physician must determine the medical necessity of services provided, based on documentation in the record, during the hospitalization such as laboratory tests, radiology charges, pharmacy charges, central supply charges, days spent in special care units or private rooms.

Step 8: Initiate correspondence and proceed with completion of the review process based on established procedure. If some of the services are found to be non-covered, a denial letter will be issued.

Step 9: Technical denials will not be issued to the member.

a. Technical denials will be sent in writing to the hospital and the physician as indicated.

<u>Day Outliers</u>

Step 1: The RC will process day outliers retrospectively.

a. The hospital must supply a copy of the medical record, a copy of the UB-04 bill and the remittance statement, within 60 days of the outlier medical record request, or outlier payment will be recouped and forfeited.

Step 2: The RC will conduct the five review functions and a subsequent service review by using the Milliman criteria to validate medically necessary days.

Step 3: If the admission was not medically necessary or appropriate i.e., no covered inpatient hospital care was needed or delivered during the stay, the admission and the outlier days will be denied.

Step 4: For an appropriately admitted acute care stay, the number of denied days cannot be used to reduce the DRG payment portion.

a. Non-covered days will be carved out of the outlier payment or, if appropriate, the entire outlier payment will be denied.

Step 5: Cases not meeting RC approval for the five review functions or cases requiring substantiation of days for medical necessity, will be referred to physicians of like practice settings or specialties as available.

Step 6: If any days are denied, a pre-denial notification letter will be sent to the physician and hospital, allowing a 30-day comment period prior to issuance of the denial notice.

a. The reviewing physician's comments will be included in the letter to the physician.

Step 7: If a response is received from the provider, a re-review will be completed.

Step 8: If the reviewing physician upholds the initial denial decision, a denial notice will be issued to the member, hospital and physician.

a. Third level reviews are available for denials involving medical necessity determinations.

Step 9: The denial notice must state the total number of days identified as medically necessary and/or not appropriate even though this number may exceed the number of days for which outlier payment is being requested.

Step10: The PR may determine the member required a lower LOC during all or part of the acute hospitalization.

a. In these situations, a denial is issued for all charges associated with the period of time the member no longer required an acute LOC.

Step 11: The hospital is notified in a cover letter attached to the denial letter that they may choose to resubmit a bill for reimbursement of the lower LOC.

Step 12: The RC will access the Credit/Adjustment form by clicking on the Credit/Adjustment task in the review queue in OnBase.

Step 13: For cost outliers, a gross adjustment is completed.

a. If the denial is for day outliers, the original claim is credited. Audit, Rates and Setting will manually price the claim for the approved number of days.

Step 14: The RC will complete an adjustment form within OnBase.

a. The form must explain in detail the reason for the credit or adjustment. It is not necessary to submit a copy of the claim or a screen shot from MMIS.

Credit/Adjustment Request Form

Credit/Adjustment Request Internal vs. Gross Adjustment Selection Screen Form

Forms/Reports:

Inpatient Initial Cost Outlier Denial Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) medical services unit reviews inpatient cost outlier services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Outlier costs in the sum of $(amount) have been identified as potential technical denials. The impending denial costs are as follows:

Technical Denial	**Amount Denied**

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

You may submit additional written information within 30 calendar days from the date of this inquiry. Your response to this is important for providing clarification and possible resolution of the identified concerns. Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received within **30 days** of the date of this inquiry, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(5)

Inpatient Initial Day Outlier Denial Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) medical services unit reviews ambulatory/outpatient services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer has recently reviewed the medical record to determine the approval of any outlier days.

Following review of the documentation in the medical record, the physician reviewer has determined that (# of days) outlier days have been denied. The physician's comments concerning this decision were:

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

You may submit additional written information within 30 calendar days from the date of this inquiry. Your response to this is important for providing clarification and possible resolution of the identified concerns. Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received within **30 days** of the date of this inquiry, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(6)
cc:

Inpatient and Outpatient Final Day Outlier Denial

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews inpatient services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The purpose of day outlier review is to verify that services provided during the hospitalization were medically necessary. Medicaid does not cover services not meeting these criteria.

Recently Medical Services notified you of a day outlier denial decision on this case and gave you an opportunity to provide additional information.

The rationale for this decision is:

Medical Services determination is based on the following:

If you disagree with medical services determination, you may request an appeal. You must submit your request in writing within 30 days from the date of this letter to the Department of Human Services, Appeals Section, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(2)
Enclosure Appeal letter
cc:

Inpatient and Outpatient Final Denial to the Member

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

In the course of performing the required review, Medical Services physician reviewers were not able to approve the medical necessity of this **hospital admission** . Your physician and the hospital representative were notified of the pending decision and were provided an opportunity to respond prior to this final determination.

Medical Services has determined that you did not know that the services denied were not covered under Medicaid. The Medicaid program will not pay the hospital for the denied services because the hospital knew or should have known that the services were not covered under Medicaid. You are responsible only for payment of convenience services and items normally not covered by Medicaid, or through spend-down payments under the Medically Needy Program, if applicable. If you have paid the hospital for any of the denied services other than those mentioned above, arrangements could be made to pay you back. Please contact your county DHS office for assistance.

Medical Services determination is based on the following:

If you disagree with Medical Services determination, you may request an appeal. You must submit your request in writing within 90 days from the date of the final denial letter to the following address: Department of Human Services, Appeals Section, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

This action is taken in accordance with 441 Iowa Administrative Code 79.9(2). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(17)

Attachment: Appeal Rights

cc:

MED - Medical Support Acute Retrospective Outpatient APC/CPT Review

Purpose: The purpose of the Medicaid ambulatory payment classification (APC) review program is to monitor the quality of care, the accuracy of coding, the medical necessity of services, and the billing of the services provided. Review will be conducted to identify and eliminate unreasonable, unnecessary, and inappropriate care provided to the Medicaid member.

If the RC has concerns regarding services that are found to be unnecessary or provided in an inappropriate setting, quality of care, or the validity of the ICD-9-CM diagnostic or procedural codes, the case is referred for PR. If the PR confirms the concerns, the provider will be given the opportunity to submit additional information. Only the information necessary to approve the procedure will be requested and reviewed. If the provider does not send additional information, the services will be denied.

The RA and/or RC will review submitted documentation to insure that the request is complete. RA and/or RC will complete a request for additional information if needed. RAs do not make clinical decisions or complete clinical interpretation of information.

Identification of Roles:
Review Assistant (RA) – will prepare and mail letters.

RC (RC) – will open a case within 30 days of receipt of medical records and review based on specific review guidelines and generate letters.

Medicaid Medical Director (MMD) – will be consulted as needed.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: The RC will review the medical record to determine if outpatient services were medically necessary and appropriate for the diagnosis and condition of the member.
Step 2: For APC reimbursement purposes, the unit of service and payment will be the visit.

a. A visit is all services provided by the hospital to an outpatient within three days, 72 hours, for a related diagnosis.

Step 3: Services provided to an outpatient who is admitted to the hospital for a related condition within 72 hours will be paid as part of the applicable DRG based payment.

a. Services that are exceptions to this definition are billed as “BATCH BILLS.”

Step 4: Please refer to the Attachment entitled “BATCH BILLS.”
Step 5: Begin with verification of the current procedural terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding system codes from the UB-04. Note the number of billed units for all HCPCS Level II codes, i.e., G0378, observation.
Step 6: The RC will validate all CPT/HCPCS codes.

a. Approve, delete, or change the codes as appropriate, according to information in the medical record.

Step 7: Changed or deleted codes which result in no APC weight value change will require no further action by the RC.

a. A billing error letter is generated and sent.

Batch Bills

The following list contains those services that are covered in an outpatient setting but may be paid by multiplying the units of service times the APC weight. Iowa Medicaid refers to these types of charges as "Batch Bills." All potential batch bill charges are exempt from the 72-hour rule. Versions 2.0 APC for potential batch bill charges along with the appropriate units are listed.

These services do not always require batch billing.

	VERSION 2.0 APC	UNIT OF SERVICE
91)	Chemotherapy by infusion	one treatment on one day
92)	Chemotherapy except by infusion	one treatment on one day
139)	Hemodialysis	one treatment on one day
140)	Peritoneal dialysis	one treatment on one day
251)	Therapeutic Nuclear Medicine	one treatment on one day
252)	Radiation therapy	one treatment on one day
271)	Occupational therapy	15 minutes
272)	Physical therapy	15 minutes
273)	Speech therapy	15 minutes
391)	Class One Chemotherapy Drugs	units as defined by J codes
392)	Class Two Chemotherapy Drugs	units as defined by J codes
393)	Class Three Chemotherapy Drugs	units as defined by J codes
394)	Class Four Chemotherapy Drugs	units as defined by J codes
395)	Class Five Chemotherapy Drugs	units as defined by J codes

Forms/Reports:

Inpatient and Outpatient Initial Billing Error Letter

DCN:

[Name]
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. Medical Services is also required to monitor the accuracy of billing for services provided to Medicaid members.

The medical record submitted for review, reflects a variance that may affect your facility's reimbursement for services based on the coverage and billing guidelines found in Chapters E & F of the Medicaid Hospital Services Provider Manual. Based upon the review of the medical record, the following pending billing discrepancies have been identified:

Medical Services is providing you an opportunity to discuss this medical record. To assure that the reviewer considers any verbal information not supported by the medical record, please submit a copy of your addendum to the medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination.

Your response to this is important for providing clarification and possible resolution of the identified concerns. Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

To assure that the reviewer considers any verbal information not supported by the medical record, please submit a copy of your addendum to the medical record.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(16)

Inpatient and Outpatient Final Billing Error Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MMDD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

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If the facility or physician disagrees with Medical Services determination, either party may request a re-review. Your written response must be received within **60 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

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Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(13)

Inpatient and Outpatient Initial Quality Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB:
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer , has raised some questions regarding the .

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received within 30 days of the date of this inquiry, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

The information in this letter is confidential and may be redisclosed only in accordance with federal regulations found in 42 CFR 476.107-108. The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(18)

Inpatient and Outpatient Final Quality Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services reviews **inpatient** services provided to Iowa Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The following concern has been upheld:

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. You must submit your request for a re-review in writing within **60 days** from the receipt of this notice in writing by faxing to 515-725-1355 or mail to

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Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

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Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(15)

Inpatient and Outpatient Initial Utilization Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MMDD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer , has raised some questions regarding the .

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received in Medical Services within **30 days** of the date of this letter, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(19)

cc:

Inpatient and Outpatient Final Utilization Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services reviews **inpatient** services provided to Iowa Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The following concern has been upheld:

If you disagree with Medical Services determination, you may request an appeal. You must submit your request in writing within **90 days** from the date of this letter to the Department of Human Services, Appeals Section, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(15)

Attachment: Appeal Rights

cc:

Inpatient and Outpatient Final Denial to the Member Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

In the course of performing the required review, Medical Services physician reviewers were not able to approve the medical necessity of this **hospital admission** . Your physician and the hospital representative were notified of the pending decision and were provided an opportunity to respond prior to this final determination.

Medical Services has determined that you did not know that the services denied were not covered under Medicaid. The Medicaid program will not pay the hospital for the denied services because the hospital knew or should have known that the services were not covered under Medicaid. You are responsible only for payment of convenience services and items normally not covered by Medicaid, or through spend-down payments under the Medically Needy Program, if applicable. If you have paid the hospital for any of the denied services other than those mentioned above, arrangements could be made to pay you back. Please contact your county DHS office for assistance.

Medical Services determination is based on the following:

If you disagree with Medical Services determination, you may request an appeal. You must submit your request in writing within 90 days from the date of the final denial letter to the following address: Department of Human Services, Appeals Section, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

This action is taken in accordance with 441 Iowa Administrative Code 79.9(2). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(17)

Attachment: Appeal Rights

cc:

Forms/Reports:
N/A

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Review of Non-Inpatient Programs (NIP) and Observation

Purpose: The RC will review observation services for stays lasting longer than 36 hours, to assess whether the admission and continued stay was medically necessary and if the appropriate quality of care was provided. Review will be conducted on all cases identified to determine whether the observation services and/or NIP were medically necessary for the member's condition. Each case needs to be reviewed to determine the accuracy of the billing, the quality of services, and the appropriateness of the outpatient setting. Review will be conducted to identify and eliminate unreasonable, unnecessary, and inappropriate care provided to the Medicaid member.

Identification of Roles:
Review Assistant (RA) – will prepare and mail letters.

Review Coordinator (RC) – will open a review case within 30 days of receipt of medical records and complete review based on specific review guidelines and generate letters.

Medicaid Medical Director (MMD) – will be consulted as needed.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: A random sample of claims paid for the NIP will be selected for retrospective review. Outpatient programs include:

a. Substance abuse
b. Pain Management
c. Cardiac Rehabilitation
d. Pulmonary Rehabilitation

Step 2: The RC will conduct review for the outpatient substance abuse programs for the non-managed care Medicaid member.

a. Common identifying information such as member name, member SID, and dates of service on all reviews must be validated with the medical record.

Step 3: If services are found to be unnecessary or provided in the inappropriate setting, inappropriate billing occurred, or the quality of the services are questioned, the provider will be given an opportunity to submit additional information prior to the final review determination. Only the information necessary to approve the procedure will be requested and reviewed. Upheld decisions will result in payment consequences to the facility.

Observation Services Overview

The purpose of observation services is to assess a member's needs, either for inpatient admission or other disposition. Use of the observation bed allows the physician to admit a member to the hospital for a limited time for observation or repeat examination and/or short-term treatment in order to establish a diagnosis.

Clarifications for course of an illness, or need to further define care and/or discharge disposition.

In order for observation services to be considered reasonable and necessary, the member must have an acute medical condition or complication with a significant degree of instability. Observation services generally do not exceed 36 hours, although certain circumstances may dictate extension of this time period. The physician should use a 24-hour period as a benchmark when considering use of these services. Although certain circumstances may require extension of this time period, observation services should never be substituted for medically appropriate inpatient admissions.

The decision whether or not to admit the member as an inpatient is the responsibility of the physician. The intent of the physician at the time of the initial evaluation determines whether the member is admitted as an inpatient or as an outpatient. This intent must be clearly documented in the medical record.

Indications for Observation Services

Observation services MAY BE INDICATED for:

a. Ruling out any symptomatic conditions where a specific diagnosis not established,
b. Conditions likely to respond quickly to treatment, and
c. Care following ambulatory surgery services if the member experiences a reaction to or complication from the surgery that requires monitoring or treatment beyond the routine postoperative recovery period.

An example of appropriate use of observation services could be a member presenting to the hospital with complaints of nausea, vomiting, and abdominal pain. Physical findings in the emergency department are negative and laboratory results indicate mild dehydration. The member is admitted to observation status and treated with IM anti-emetics and IV hydration. After 15 hours the member's symptoms have subsided and the physician assesses that the member is ready for discharge.

Observation services may continue past 24 hours if additional time is necessary to stabilize the member. However, extending the length of stay under observation status must be medically necessary and not for the convenience of the physician or the member.

At the end of 24 hours, the physician should reassess the member and clearly document in the medical record one of the following:

a. The member's condition requires additional treatment as an inpatient, or
b. The member's condition has improved satisfactorily to allow discharge within a few hours.

Contraindications to observation services

Observation services MAY NOT BE COVERED when:

a. The member is being held because of social factors,
b. The services are not reasonable or necessary for the diagnosis or treatment of the member,
c. The services are provided for the convenience of the physician or the member,
d. The services are covered under another benefit, (e.g., Medicare Part A or B, Medicaid APC),
e. The services are routine preparation and recovery for diagnostic testing, or
f. The services are already covered in an Ambulatory Surgery Center (ASC) payment rate and are not eligible for additional coverage. Use of the outpatient surgical suite and recovery room are included in the ASC payment rate.
g. Routine outpatient blood transfusions are generally not covered. The use of the hospital's facilities is inherent in the administration of the blood and is included in the payment for administration.
h. Medical records exhibiting the appropriate admission criteria to the observation status, or the NIP criteria, the correct billing of the claim units, and without any quality concerns during the initial review are classified as complete.
i. When a case is referred for the appropriate setting or quality of care, a case summary is prepared and the entire medical record is sent to an appropriate PR. If the PR indicates that no further action is indicated, the review completion date is the date the physician reviewed the medical record and completed the physician's rationale form.
j. When the PR for the appropriate setting and/or Quality of Care (QOC) questions a case for billing of the claim, and the opportunity to discuss has been afforded, the review completion date is the date the final notice is sent. A final notice must be sent regardless of the outcome of the re-review.
k. When a case is questioned for medical necessity, appropriateness of setting, or validity of the diagnostic or procedure codes, 30 calendar days from the date of the initial letter, must be given to the provider to discuss the proposed denial with a physician, and if necessary, to provide additional information pertaining to the questioned case.
l. When a case has been technically denied because the medical record was not submitted timely, upon receipt of the medical record, the RC has 30 calendar days in which to complete the review.

Documentation Review

Step 1: If a review referral or determination cannot be made on a claim because part of the medical record is illegible or physically missing, the RC will allow 15 calendar days for the facility to produce the record or the missing portion of the record.

Step 2: If the requested documentation is not produced, or is not legible, a technical denial may be issued. When the missing part of the record is supplied, the RC will reopen the case and proceed with the review. If the missing information is not obtained and a technical denial is not issued, a referral may be made to a PR.

Initial Review Procedure

Review of the medical record must indicate outpatient hospital care and services were medically necessary and appropriate for the diagnosis and condition of the member. Begin review of medical records by validating all CPT and HCPCS codes, application of the criteria specific to the NIP program, the Milliman Care Guidelines, and the Generic Quality Screen Guidelines for the observation services the member received, e.g., cardiac rehabilitation, versus observation services.

The RC will follow the instructions contained in the program specific criteria and approve outpatient medical services based on application of the criteria.

For observation services, the RC may approve if the care required could only be provided in a hospital setting and documentation meets observation services criteria. See observation services screening criteria in MedSrv/Criteria/All Programs Criteria.

Refer to PR when:

a. The outpatient or NIP criteria are not met.
b. There is a question about the medical necessity, setting, or quality of care concern affecting the overall quality of care provided. Be careful to distinguish the difference in practice preference from a quality of care concern.
c. When there is a discrepancy about the appropriate setting for observation versus an acute admission, give the benefit of the doubt to the attending physician.
d. There are often discrepancies regarding the appropriate postoperative setting i.e., extended ambulatory services versus observation services versus an acute admission.
e. Routine ambulatory surgical procedures would not normally require postoperative observation services.

The member can stay overnight in extended ambulatory outpatient services for routine postoperative care, i.e., intravenous antibiotics and pain medication. Observation services may be appropriate after an ambulatory procedure if there has been a documented intra-operative or postoperative complication, i.e., extensive bleeding or postoperative vomiting. These cases may require a physician review to determine the medical necessity of the observation services following an outpatient procedure. The RC will identify the procedure performed, the LOC ordered and provided, and the adequacy of the services. Refer only if there is a potential concern. When presenting questions to the PR regarding subsequent services at observation LOC, the RC will be specific, e.g., the nurses' notes indicated the member was taking oral food and fluids and up playing in the room by 1700 on 8/28. However, he was not discharged until 0900 on 8/29. Was the initial admission to observation services medically indicated? Were the services provided after 1700 on 8/28

medically necessary? Could this member have been safely discharged earlier? If so, when? Whenever possible, the physician reviewer selected for PR should be of the same specialty and similar practice setting as the attending physician.

Correspondence

If during initial case screening, criteria are not met or the RC has concerns regarding the quality of care, a referral will be made to a PR. When potential adverse determinations occur, an initial adverse letter is sent and the provider is given an opportunity to submit additional information prior to the final review determination.

When the PR identifies a potential denial, correspondence is sent to the physician responsible for admitting the member and the facility liaison. A 30-day response time is allowed.

If additional information is received, the RC reviews the correspondence and the case is sent to another PR for a re-review. If the decision is upheld, a final letter will be sent. An appeal process or third level review for coding and billing are available to all involved parties when there are payment consequences associated with the review decision.

Billing Errors

Verify the number of units and the appropriate code billed with the medical record. This information is found in MMIS.

According to the Centers for Medicare and Medicaid Services (CMS) Program Memorandum (PM) A-02-129 (CR 2503), dated January 3, 2003, http://www.cms.hhs.gov/manuals/pm trans/A02129.pdf, “the time begins at the clock time appearing on the nurse’s observation admission note, which should coincide with the initiation of observation care of with the time of the patient’s arrival in the observation unit.” If the time is not included in the nursing documentation, the time starts when the physician’s order is written. For surgical members, the observation time begins when the member is discharged from the post anesthesia area. If emergency department (ED) services were provided prior to observation services, the observation time begins when the member is discharged from the ED. Refer to nurses’ notes, emergency department notes, flow sheets, etc., to determine time of presentation.

The discharge time is when the member leaves the observation unit with the documentation indicating staff sign-off when all clinical or medical interventions have been completed.

The total hours are calculated and compared to the billed units of service and the units reimbursed on the claims information.

If the minutes of service are less than 30 minutes, the time is rounded down for the total hours. If the minutes are 30 minutes or greater, the time is rounded up to the next total hour.

Each of the NIP's has a specific HCPCS code with different units and reimbursements based on each of the HCPCS codes.

Per DHS Policy, a rule does not exist that Medical Services have any obligation or would expect a provider to be notified in the event they under bill a service.

If an initial service denial is reversed and a billing discrepancy is determined, an initial letter regarding the billing issue is sent at the same time the utilization reversal letter is sent. The medical record returns to the 30-day tickle file.

Cost Savings

Cost savings are determined after the final letter is sent. When the final letter is sent regarding a utilization issue, the number of units billed and approved is entered. After the final letter the RC completes an internal adjustment request instructing the claims payor on how to process the claim.

Forms/Reports:

Inpatient and Outpatient Initial Billing Error Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. Medical Services is also required to monitor the accuracy of billing for services provided to Medicaid members.

The medical record submitted for review, reflects a variance that may affect your facility's reimbursement for services based on the coverage and billing guidelines found in Chapters E & F of the Medicaid Hospital Services Provider Manual. Based upon the review of the medical record, the following pending billing discrepancies have been identified:

Medical Services is providing you an opportunity to discuss this medical record. To assure that the reviewer considers any verbal information not supported by the medical record, please submit a copy of your addendum to the medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination.

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Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

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Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(16)

Inpatient and Outpatient Final Billing Error Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

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Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(13)

Inpatient and Outpatient Initial Utilization Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer , has raised some questions regarding the .

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received within 30 days of the date of this inquiry, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

The information in this letter is confidential and may be redisclosed only in accordance with federal regulations found in 42 CFR 476.107-108. The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

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Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(18)

Inpatient and Outpatient Initial Final Utilization Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB:[MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services reviews **inpatient** services provided to Iowa Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The following concern has been upheld:

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Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

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Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(15)

Inpatient and Outpatient Final Denial to the Member Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

In the course of performing the required review, Medical Services physician reviewers were not able to approve the medical necessity of this **hospital admission** . Your physician and the hospital representative were notified of the pending decision and were provided an opportunity to respond prior to this final determination.

Medical Services has determined that you did not know that the services denied were not covered under Medicaid. The Medicaid program will not pay the hospital for the denied services because the hospital knew or should have known that the services were not covered under Medicaid. You are responsible only for payment of convenience services and items normally not covered by Medicaid, or through spend-down payments under the Medically Needy Program, if applicable. If you have paid the hospital for any of the denied services other than those mentioned above, arrangements could be made to pay you back. Please contact your county DHS office for assistance.

Medical Services determination is based on the following:

If you disagree with Medical Services determination, you may request an appeal. You must submit your request in writing within 90 days from the date of the final denial letter to the following address: Department of Human Services, Appeals Section, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

This action is taken in accordance with 441 Iowa Administrative Code 79.9(2). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(17)

Attachment: Appeal Rights

cc:

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Outpatient Generic Quality Screen Review

Purpose: The RC will screen all cases to determine that care provided meets acceptable standards of medical care. This will be done by applying the Centers for Medicare and Medicaid Services (CMS) outpatient generic quality screens, for unnecessary and inappropriate care provided to the Medicaid recipient.

Identification of Roles:
Review Assistant (RA) – will prepare and mail letters.

Review Coordinator (RC) – will open a case for review within 30 days of receipt of the medical records and review based on specific guidelines.

Medicaid Medical Director (MMD) – will be consulted as needed.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:

Initial Review
CMS's outpatient generic quality screens (GQS) appropriate to the case will be applied to outpatient hospital cases. The specific screens are attached.

If there is no concern regarding the care provided and no screen failure, RC places an "A" code (coordinator approved) in the specific generic screen and level and outcome spaces on the Quality Tab in MQUIDS.

A screen occurrence is a screen failure. If information is not documented or fails the screen guidelines, it is an occurrence and, therefore, a screen failure. The RC may determine that a screen failure is not a potential quality problem and will not refer the case to a PR.

Using the outpatient generic quality screens, the following guidelines for "Z" codes are provided to assist you in determining if a screen failure impacts the overall quality of care. These are guidelines only. You may choose to refer even if these do apply. Likewise, it may be appropriate to not refer if an acceptable variance is exceeded.

Generic Quality Screen 5:

Abnormal results not addressed with no apparent medical concerns including but not limited to:

- 10 percent (+ or -) variance from the hospital's "normals"
- Elevated blood sugar in a diabetic (not newly diagnosed)
- Low hemoglobin/hematocrit in a chronically anemia member
- Expected abnormal ABGs in a member with a chronic lung disease (PO2 saturation less than 90 and PCO2 saturation greater than/equal to 50 should be explained)
- Elevated cholesterol and/or triglycerides in a member with known hyperlipidemia
- Elevated triglycerides in a member with known heart disease
- Elevated BUN and creatinine in a member with chronic renal failure
- Decreased hemoglobin in a member with chronic renal failure
- Elevated alkaline phosphatase and liver function tests in a cancer member
- Elevated albumin in a cancer member
- Serum calcium (Use the formula below or the + or – 10% variance from hospital's normals.)

In hypoproteinemic states, the total serum calcium does not accurately reflect the useable calcium. When the serum protein decreases, the total serum calcium would decrease.

For review purposes for every 1 Gm. decrease in serum protein, the calcium decreases approximately 0.8 mg. Using the range for total protein of 6.4 – 8.3 Gm/dL and calcium 8.4 – 10.2 mg/dL, use the midpoint of those ranges as reference.

Example 1: If the total protein is 5.3 (decrease of 2 Gm. from the midpoint of the range of normal the total calcium could be 7.5 mg/dL and still be within normal limits (WNL) a decrease of 1.6 mg from the midpoint of the range of normal.

Example 2**:** The serum protein is 4.3 Gm/dL. How low can the calcium be and be "normal?"

- 4.3 is 3 Gm. below normal.
- 3 x 0.8mg = 2.4mg
- 9.1mg/dL is midpoint of calcium range minus 2.4 = 6.7mg/dL (still a "normal" calcium)
- Labs e.g., decreased hemoglobin [9-11] and asymptomatic, elevated CPK after heart surgery or other major surgery
- Decreased CBC values on a member receiving chemotherapy
- Abnormal electrolytes on an end-stage renal disease member
- Abnormal electrolytes on a member receiving chronic diuretic therapy (+ or – 5% for potassium, sodium, and chloride)
- Abnormal LFT's with severe left heart failure
- WBC's 10 or greater present in a voided urine specimen on an asymptomatic member, especially if epithelial cells are present indicating contamination
- Lack of documentation of an expected death with no apparent medical concern.
- Unavoidable falls with no apparent medical concern.

- Unavoidable falls are defined when documentation supports that appropriate measures were taken to prevent a fall yet one occurred.
- Medication error or adverse drug reaction with no serious potential for harm and no special measures to correct with no apparent medical concern.
- Temperature above 101 degrees with no apparent medical concerns.
- Diastolic below 50 or systolic above 180 with no apparent medical concerns.
- Pulse less than 50 or greater than 120 with no apparent medical concerns.
- Significantly increased or decreased wound drainage with no apparent medical mismanagement.

Generic Quality Screen 10:
Lack of documentation of an expected death with no apparent medical concern.

Generic Quality Screen 15:
Unavoidable falls with no apparent medical concern. Unavoidable falls are defined when documentation supports that appropriate measures were taken to prevent a fall yet one occurred.
Generic Quality Screen 18
Medication error or adverse drug reaction with no serious potential for harm and no special measures to correct with no apparent medical concern.

Generic Quality Screen 3:
Temperature above 101 degrees with no apparent medical concerns.

Generic Quality Screen 2:
Diastolic below 50 or systolic above 180 with no apparent medical concerns.

Generic Quality Screen 4:
Pulse less than 50 or greater than 120 with no apparent medical concerns.

Generic Quality Screen 7:
Hospital acquired decubitus or deterioration of decubitus.
<u>General Quality Review</u>
General quality review is intended to identify concerns related to other quality concerns unrelated to generic quality screens.

If any potential quality concerns are identified, staff must evaluate if the concern can be coded and/or referred to a PR as a generic quality screen failure. If the concern is unrelated to any GQS, then refer the case to a PR as a general quality concern.

Forms/Reports:

Inpatient and Outpatient Initial Quality Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based on the medical record provided by the facility, a Medical Services physician reviewer , has raised some questions regarding the .

Medical Services recognizes that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) also may not be readily apparent. While either a physician or the facility representative individually may respond to this inquiry, Medical Services strongly encourages a coordinated response.

Medical Services is providing you an opportunity to discuss this medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

If a response is not received within 30 days of the date of this inquiry, a reviewer will make a final determination regarding the concerns raised in this letter based on the information available in the medical record. If a utilization concern is confirmed, it will result in denial of payment.

The information in this letter is confidential and may be redisclosed only in accordance with federal regulations found in 42 CFR 476.107-108. The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(18)

Inpatient and Outpatient Final Quality Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services reviews **inpatient** services provided to Iowa Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The following concern has been upheld:

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. You must submit your request for a re-review in writing within **60 days** from the receipt of this notice in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(15)

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Outpatient Physician Review

Purpose: Retrospective review utilizes explicit Milliman Care Guidelines when conducting reviews. Screening criteria are used by nurse reviewers and do not constitute physician standards of care. When information provided by the facility does not meet the criteria for RC approval, the medical record is sent to a PR. Unless the PR is the MMD, the PRs are licensed, practicing doctors of medicine or osteopathy. Whenever possible, Medical Services will use PRs of similar specialty and who practice in similar settings as the attending physician. The PRs are provided the member's medical information as supplied by the facility and the attending physician.

Only PRs make denial decisions. The PRs include licensed health care professionals in the same category as the attending provider. Denials made by the Clinical Assistant to the Medicaid Medical Director will be reviewed by the physician MMD. Notice of the availability of the peer-to-peer conversation is included on the IME website http://www.ime.state.ia.us

1. Click on providers
2. Click on important provider announcements
3. Click on peer-to-peer conversation

The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances.

Identification of Roles:
Review Assistant (RA) – prepares medical record information and physician rationale sheet for physician reviewer; proofs letters and sends to the mailroom for mailing.
Review Coordinator (RC) – prepares a case summary for the PR, reviews physician findings and rationale and prepares summary for inclusion in letters.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: If the RC questions cases for medical necessity, appropriateness of setting, or quality of care, it will be referred to the MMD or CAMD. The medical record, supporting documentation, MD router will be sent through the OnBase workflow to the MMD or the CAMD.

Step 2: The MD Router is used for physician review purposes via the OnBase system. The demographic information is partially filled in automatically. Any missing information is typed in by the RC. A case summary is typed in from the RC's notes about each case. If the MMD or the CAMD approves the LOC procedure, the process is complete. If the PR determines the care is not medically necessary, or not provided in the appropriate setting, the RA and/or RC will send an initial denial letter to the attending physician and the facility liaison. The letter requests additional information pertinent to the initial denial and allows a 30-day time period to provide the information.

Step 3: If a response is received within the 30 days, the additional information and the medical record are sent to a PR. If the PR approved the LOC procedure, the process is complete and the RC sends a resolved issue letter. If the PR upholds the initial denial decision, or if there is no response to the letter requesting additional information, a final denial letter is mailed to the member, the attending physician and the facility liaison.

The PRs make determinations based on medical judgment, not criteria. Only PRs may make a denial determination involving medical necessity.

The PRs, when they are not the MMD or CAMD, are compensated based on an hourly rate without regard to the review outcome.

Members, their representatives or providers may request an appeal hearing for any denial determination that results in payment consequences. Any party may submit additional information for review.

Step 4: The third level reviews for coding and billing discrepancies are also available with the RC. For a 3nd level utilization re-review request, all the information gathered is provided to the PR and submitted to MMD via OnBase. If the re-review is to be done by a PR other than the MMD, all information is gathered and mailed to a PR. A PR conducts a re-review utilizing the medical record and all relevant documented information submitted for review.

When a case is questioned for utilization, coding, or quality of care and the PR indicates that no further action is indicated, the review close date is the date the physician reviews the medical record and the physician summary is completed. The RC sends a resolved utilization letter.

When a case is questioned for coding or by the PR for utilization and/or quality of care, and the opportunity to discuss the case has been afforded, the review close date is the

date the final letter is sent. The RC will complete the appropriate letters with physician's rationale if the PR denies services.

Step 5: The RA will proof letters, print and send to the IME mailroom for distribution.

Forms/Reports:

MD Router

Medical Services - Request for Medical Director Review
Route all requests for Medical Director review to Medical Services

☐ DHS Policy Staff ☐ Member Services ☐ Retro Review
☐ EPSDT ☐ Pharmacy Services ☐ SURS
☐ Exception to Policy ☐ Pre-Pay ☐ Targeted Case Mgmt
☐ Lock-in ☐ Prior Authorization ☐ Waiver
☐ Long Term Care ☐ Provider Services ☐ Medical Support
☐ Other (specify) _____

Person requesting review: _____ Ext: _____

Date:	Date of Service:
Review Type:	Attending Physician:
Member Name:	Telephone #:
Member ID:	Hospital ID:
Admission Date:	Hospital Name:
Discharge Date:	Hospital City:

Case Summary: (explain reason for Medical Director review - include known facts, concerns, etc.)

_____

_____

_____

_____

Medical Director rationale for decision: _____

_____

_____

_____

_____

☐Concern Identified ☐No Concern Identified ☐Approve ☐Deny

☐Immediate Action Recommended: _____

Please indicate amount of time spent reviewing this case: _____

External consultants utilized: ☐Yes (identify below) ☐No

External consultant(s): _____

Medical Director Signature: _____ Date: _____

MDRouter/#05-
Rev. 6/14

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Review Physician Review for Quality Concerns

Purpose: Medical Services utilizes explicit physician developed written criteria when conducting reviews. Screening criteria are used by RCs and do not constitute physician standards of care. When information provided by the facility does not meet the criteria for RC approval, the medical record is sent to a PR. If the PR is not the MMD, the PRs are licensed, practicing doctors of medicine or osteopathy. Whenever possible, Medical Services will use PRs of similar specialty and who practice in similar settings as the attending physician. The PRs are provided the member's medical information as supplied by the facility and the attending physician.

Identification of Roles:
Review Assistant (RA) – prepares medical record information and physician rationale sheet for physician reviewer.

Review Coordinator (RC) – prepares a case summary for the PR, reviews physician findings and rationale and prepares summary for inclusion in letters.

Medicaid Medical Director (MMD) – reviews referred cases and makes a decision based on the medical record and supporting documentation.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: The RC will refer any case to the PR failing a GQS, medical necessity, or any case where the quality of care delivered is questioned.
Step 2: The PR may determine that a potential quality concern exists.

a. If a potential quality concern is identified, the PRs need to confirm or resolve the potential quality concern or identify the responsible provider(s) (physician, facility, or other agency); and identify what should have been done to prevent the problem.

Step 3: Referrals to PR for GQS failures are made by completing the physician referral form.

Step 4: The PRs must identify the provider of concern. RC should include the provider's name, who they believe is responsible for the screen failure, e.g., the physician who wrote the order and provided the care. This will assist the PR and provide a reference if the provider must be contacted for clarification.

Step 5: For reviews that are sent to a PR, staff should complete the generic quality screen section with a "Z" to indicate that the decision is pending.

Step 6: Utilize the MMD for the PR. The MMD may request a referral to a PR of same specialist as the provider of concern. If unable to obtain the same specialist, document reasons in the note screen.

Step 7: The definition of a quality problem as defined by CMS is a problem with significant or the potential for significant adverse effect(s) on the member. "Significant adverse effect" is defined as unnecessarily prolonged treatment, complications or readmission; or member management, which results in anatomical or physiological impairment, disability, or death.

Step 8: A quality problem may be assigned following physician review for any non-justified screen failure.

Step 9: If the case is assigned a Gross and Flagrant (G&F) concern during initial review, it must be reviewed by another physician of like specialty.

a. If the second reviewer does not concur that the case is a G&F, please refer the case to your manager or designated staff for further direction.

Step 10: Components of the inquiry letter will include brief case summary, list of potential quality concern(s), restatement narrative of the category of concern and supporting clinical information

Step 11: Each party who receives the inquiry letter will have thirty days to respond. The notification will encourage the facility and physician(s) to discuss the concern at hand and prepare a joint response to IME, Medical Services.

<u>Second Level of Quality Review Concerns Receipt of Additional Information</u>

Step 1: Anytime a physician or facility of concern responds to an initial quality letter, a re-review of the quality concern(s) must be completed.

Step 2: The quality concern should be sent to the MMD.

Step 3: If additional information is provided in writing, the RC will determine if information submitted for re-review should be referred to a physician.

Step 4: The RC will conduct a re-review, enter the outcome into MQUIDS and send on to the medical information to a PR.

Step 5: If additional information is provided over the telephone, the RC will data enter the information into MQUIDS. All review information must be dated.

Step 6: If additional information is provided in writing, the RA will obtain the medical record and log the case to the designated RC.

Step 7: If the information provided verbally or in a letter is in direct conflict with documentation present in the medical record, the PR may choose not to consider the additional information unless an addendum to the medical record is submitted.

Step 8: The RC must determine if information submitted for re-review should be referred to a PR.
Step 9: In order for the RC to approve the information submitted without referral to a PR, the information must be submitted as an addendum to the medical record, clearly address all quality concerns identified in the initial quality letter and include information that would meet criteria and could have been approved by staff if it was contained in the original reviewed medical record, except for G&F concerns, which should be directed to physician review.

a. If unable to determine whether or not to approve, please refer questions to your manager.

Step 10: If the additional information is referred to a PR, the RC must complete a physician referral form.
Step 11: If the RC believes in his/her judgment that the additional information could be provided to the PR per telephone, the RC may use this method for re-review.
Step 12: The PR's comments, in this instance, should be written by the RC and designated as a telephone review.
Step 13: The RC should sign the physician's name, cosigned with the RC name.
Step 14: If the RC believes in his/her judgment, the additional information needs to be reviewed in the presence of the medical record; the RC may send the case to MMD or mail the case to a PR.
Step 15: The RA will send final quality letters to the provider(s) of concern upholding or reversing the concern(s).
Step 16: If another individual responds on behalf of the provider or concern, the RA will consult with the manager.

Reopen of Final Quality Review Decision

Step 1: Following confirmation of a confirmed quality concern, either provider(s) may request a reopen of the case within 10 days of the receipt of the final letter.
Step 2: The responsible party/parties must provide additional information for the reopen process to take place.
Step 3: The case is sent to a PR not involved with the first two levels of review.

a. The use of a like specialist is not mandatory.

Notification

Step 1: Both the physician(s) concerned and the concerned provider are to be notified of all potential and confirmed quality concerns.

a. A provider, however, cannot have access to information about a physician's quality concerns when the information relates to services furnished at other facilities unless the affected physician consents to the disclosure.

Step 2: All notifications regarding potential quality concerns and final and re-reviewed determinations of quality concerns must meet the following specifications.

a. Because potential and confirmed quality concerns require the attention of both the provider and physician(s) concerned, the notices are to be sent to both the involved physician and the provider where the services were performed.
b. If the quality concern is thought to relate to a provider, the notices are to be sent to both the provider and the attending physician.

c. Notices, which are sent to the provider, are to be sent to both the administrative and medical staff at the provider or to the contact designated in the provider agreement.
d. It is expected that the designated contact would represent both the administrative and the medical staff.
e. The final notice of quality concern is to be issued for every case where a preliminary notice was issued. A final notice of quality concern must be sent to every physician and provider who received a preliminary notice of quality concern.
f. The notice must be issued regardless of whether or not the physician and/or provider responded to the opportunity for discussion.
g. The notice must be issued in cases where the concern is confirmed, as well as in cases where the potential concern has been resolved.
h. The notice must clearly explain that it is a final determination. It must also explain the rights of the physician and the provider to request a re-review of the determination.
i. The notice of a re-review determination is to be issued for every case where a re-review is requested. A notice of the re-review determination must be sent to the provider and to the physician(s) who received the preliminary notice of quality concern.
j. The notice must clearly explain that it is a final determination and that there are no further appeal rights.
k. If the PR agrees with the original PR that the care was gross and flagrant for concurrent or retrospective review, the Program Manager will refer the case to the Department of Inspections and Appeals (DIA) with a copy to the DHS.

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Review Third Level for Billing Errors

Purpose: When additional information that was previously not considered in the original denial, is provided by the facility or physicians for additional clarification of coding or billing.

Identification of Roles:
Review Assistant (RA) – will prepare medical record information and physician rationale sheet for physician reviewer.

Review Coordinator (RC) – will review for billing compliance and document physician reviewer's decision

Medicaid Medical Director (MMD) - internal physician providing direction and decisions from review of medical records

Physician Reviewer (PR) – external physician providing direction and decisions from review of medical records

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The RC will receive back from the facility additional information not provided with the initial denial**.**

Step 2: If the RC approves the case at the third level of review, the RC will enter approval information in MQUIDS and reversal letter will be sent and an adjustment of payment is completed.

Step 3: If the decision is upheld, a final letter of denial is sent to the provider.

Forms/Reports:

Inpatient and Outpatient Initial Billing Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Name, Last Name] ID#:
Dates of Service: - DOB: [MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. Medical Services is also required to monitor the accuracy of billing for services provided to Medicaid members.

The medical record submitted for review, reflects a variance that may affect your facility's reimbursement for services based on the coverage and billing guidelines found in Chapters E & F of the Medicaid Hospital Services Provider Manual. Based upon the review of the medical record, the following pending billing discrepancies have been identified:

Medical Services is providing you an opportunity to discuss this medical record. To assure that the reviewer considers any verbal information not supported by the medical record, please submit a copy of your addendum to the medical record. Your written response must be received within **30 days** of the date of this letter in order for the information to be considered in Medical Services final determination.

Your response to this is important for providing clarification and possible resolution of the identified concerns. Submit your request in writing by faxing to 515-725-1355 or mail to

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

To assure that the reviewer considers any verbal information not supported by the medical record, please submit a copy of your addendum to the medical record.

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(16)

Inpatient and Outpatient Final Billing Letter

[Name] DCN:
[Address]
[City], [STATE] [Zip]

RE: Member: [First Initial, Last Name] ID#:
Dates of Service: - DOB: {MM/DD]
Hospital:

Dear :

The Iowa Medicaid Enterprise (IME) Medical Services unit reviews **inpatient** services provided to Medicaid members. Pursuant to the Department of Human Services (DHS), Medical Services reviews medical records to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Medical Services determination is based on the following:

If the facility or physician disagrees with Medical Services determination, either party may request a re-review. Your written response must be received within **60 days** of the date of this letter in order for the information to be considered in Medical Services final determination. Your response to this is important for providing clarification and possible resolution of the identified concerns.

Submit your request in writing by faxing to 515-725-1355 or mail to:

Iowa Medicaid Enterprise
Medical Services Unit Acute Retrospective Review
P.O. Box 36478
Des Moines, IA 50315

This action is taken in accordance with 441 Iowa Administrative Code 79.1(16). The information in this letter is confidential and may be disclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

If you have questions regarding this review, you may call Medical Services Acute Retrospective Review locally at 256-4623 or 1-800-383-1173.

Iowa Medicaid Enterprise
Medical Services/
Acute Retrospective Review/(13)

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Acute Retrospective Review Appeal Process

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at *http://www.dhs.state.ia.us/dhs/appeals/appeal_decision.html*. The notice of decision letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

Refer to appeals section from the Policy Support\Operational Procedure. The Policy Support operational and procedure is located at IME universal/operational procedures/medical services/Policy Support.doc.

Performance Standards:

Performance standards are not specified for this procedure.

Forms/Reports:
N/A

RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

MED - Medical Support Retrospective Review Reports and Internal Quality Control

Purpose: Quarterly report of cost savings by denial type will be reported. The Internal Quality Control.(IQC) will be conducted on each Review Coordinator on a quarterly basis.

Identification of Roles:
Review Coordinator (RC) – will complete IQC review and input data into system to track cost savings for reporting.

Review Assistant (RA) – will provide assistance and enter all data in spreadsheet.

Manager – will provide oversight of all performance reports, generate reports and evaluate need the for program improvement.

Medicaid Medical Director (MMD) - provides medical direction in the Retro Review program.

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: Each RC will track facility denials and enter into a spreadsheet. Denials are by location, inpatient and outpatient.
Step 2: The RC will enter the following information:

a. Date, name of member
b. SID#
c. Date of service
d. IP or OP
e. Denial Type
f. Cost Savings
g. Notes
h. Provider Number
i. RC
j. TCN

Step 3: This information is entered at the time of the denial. The cost savings are reported by quarter. The RC will add dollar amounts according to the type of services or type of denial. If the case is reversed, the amount will be removed from the report.
Step 4: The amount of savings and adjusted savings is calculated on a monthly basis.
Step 5: Quarterly the information is added to a statistical spreadsheet.
Step 6: Internal Quality Control (IQC) is a peer review process completed monthly in which team members review medical records for appropriate decisions, use of criteria and referral to peer review. The goal is to have an overall 95 percent agreement on all questions. If the goal is not met, review coordinators will discuss and reach consensus.

Step 7: A total of three reviews for each review coordinator completed from the previous month will be randomly selected. On the first of each month, OnBase will automatically select cases and insert into the RCs workflow for IQC completion.
Step 8: The RC will complete the IQC checklist for each case selected. Completed IQC worksheets will be forwarded to the manager.
Step 9: If there is a disagreement with the results, a comment period is allowed to rebut the decisions.
Step 10: The RA will accumulate all data and input into a spreadsheet documenting statistics on each question answered and agreement rate.
Step 11: This information will be documented and discussed at monthly team meetings for learning by the team.

Forms/Reports:

Retrospective Review Denial and Cost Savings Quarterly Report

	Number of reviews completed	Number of denials	Percentage of denials	Number of type of denial	Percentage of type of denial
Inpatient					
Billing errors					
TD					
Adm denial					
Proc. denial					
Disposition change					
DRG change					
Other denial					
Outpatient					
Billing errors					
TD					
LOC denial					
Proc. denial					
Other denial					

Date	Name of Member	SID#	TCN	Date of Service	Medically Necessary	Not Medically Necessary	IP/OP	Cost savings	Notes	Provider #	RC

Retro IQC worksheet from OnBase

1. If the medical record documentation was incomplete did the reviewer request the missing documentation?	N/A
2. Was the initial review completed within 30 days of receiving the complete medical record?	Yes
3. If the medical record documentation did not support the medical necessity to approve the IP services was the case sent to PR appropriately?	Yes
4. Was the Milliman Care Guideline used to approve the IP services appropriate?	N/A
5. If the case failed any of the Quality indicators was it referred to PR appropriately?	N/A
6. If the medical record documentation did not support the DRG was the case referred to PR appropriately?	N/A
7. Was the correct letter(s) selected?	Yes
8. Was confidentiality maintained (i.e. letter sent to the correct person and address)?	Yes
9. Were all the screens in MQUIDS filled out completely?	Yes/No

MED - Medical Support Acute Retrospective Review Disruption of Business Plan

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming.

Identification of Roles:
Review Assistant (RA) – receives medical records and send to RC.

Review Coordinator (RC) – conducts a medical review for each medical record received.

Manager – provides direction, training, and oversight.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: The RA will receive medical record from provider.
Step 2: The RA will keep a log of each medical record and which RC is assigned to the case.
Step 3: The RC will complete the review utilizing a worksheet and complete the following fields:

Reports/Forms:

Outpatient Review Notes

Demographics**:**

Member SID: _____

Member name: _____

DCN: _____

Coordinator: _____

Provider ID#: _____

Provider NPI #: _____

Provider Name: _____

Dates of Service: _____

Attending Physician: _____

Physician Review _____

Physician reviewer name: _____

Contact date: _____

Criteria:

APC review:

Billed APC: _____

Approved APC: _____

Quality Review Medical Quality Indicators:

A=approved Z=referred to PR X=not applicable

1. Adequate discharge planning_____

2. BP stable 24 hrs before DC_____

3. Temperature not > 101 oral for 24 hours_____

4. Pulse not < 50 or > 120 within 24 hours_____

5. Abnormal tests/procedures addressed or resolved_____

6. IV fluids or drugs after midnight on day of discharge_____

7. Purulent/bloody drainage within 24 hours of discharge_____

8. Death during/following surgery_____

9. Death within 24 hours of transfer out of ICU_____

10. Other unexpected death_____

11. Infectious disease and blood cultures addressed (bacteremia)_____

12. Unscheduled return to surgery_____

13. Unplanned surgery- due to error during/prior to surgery_____
14. Complication of anesthesia

15. Fall - appropriate assessment/service_____

16. Transfusion error or reaction _____

17. Hospital acquired decubitus or deterioration of decubitus_____

18. Med or medication error or drug reaction _____

19. Care or lack of care result in complications_____

Psychiatric Quality Indicators:

A=approved Z=referred to PR X=not applicable

20. Adequate psychiatric assessment_____

21. Adequate treatment planning_____

22. Evaluation to identify change in status_____

23. Adequate/appropriate use of medications_____

24. Medications monitored_____

25. Adverse drug reaction or medication error with harm_____

26. Harm/trauma suffered in hospital-suicide or self-injury_____

27. Fall - appropriate assessment/services_____

28. Seizure addressed/treated_____

29. Loss of consciousness addressed/treated_____

30. Other serious injury or complication addressed_____

31. Restraints appropriate use _____

32. Restraint-physical or mechanical safe_____

33. Inappropriate use of seclusion_____

34. Seclusion appropriate_____

35. ECT appropriate_____

36. ECT safe_____

37. Discharge planning appropriate_____

38. * All deaths in the psych unit require PR

Notes:
Rationale for approving/referring the observation admission:

Rationale for validating/referring the HCPC/CPT codes:

If observation admission/procedure is denied: Documentation submitted did not support the medical necessity for this admission/procedure and is denied for the following reasons:

IP Review Notes

Demographic:

Member SID: _____

Member name: _____

DCN: _____

Coordinator: _____

Provider ID#: _____

Provider NPI #: _____

Provider Name: _____

Dates of Service: _____

Attending Physician: _____

Physician Review: _____

Physician reviewer name: _____

Contact date: _____

Criteria:

DRG review:

Billed DRG:_____

Approved DRG:_____

Quality Review Medical Quality Indicators:

A=approved Z=referred to PR X=not applicable

1. Adequate discharge planning_____
2. Blood pressure stable 24 hrs before discharge_____
3. Temperature not > 101 oral for 24 hours_____
4. Pulse not < 50 or > 120 within 24 hours_____
5. Abnormal tests/procedures addressed or resolved_____
6. IV fluids or drugs after midnight on day of discharge_____

7. Purulent/bloody drainage within 24 hours of discharge_____

8. Death during/following surgery_____

9. Death within 24 hours of transfer out of ICU_____

10. Other unexpected death_____

11. Infectious disease and blood cultures addressed (bacteremia)_____

12. Unscheduled return to surgery_____

13. Unplanned surgery - due to error during/prior to surgery_____

14. Complication of anesthesia_____

15. Fall - appropriate assessment/service_____

16. Transfusion error or reaction _____

17. Hospital acquired decubitus or deterioration of decubitus_____

18. Medication error or drug reaction addressed_____

19. Care or lack of care result in complications_____

Psychiatric Quality Indicators:

A=approved Z=referred to PR X=not applicable

20. Adequate psychiatric assessment_____

21. Adequate treatment planning_____

22. Evaluation to identify change in status_____

23. Adequate/appropriate use of medications_____

24. Medications monitored_____

425 Adverse drug reaction or Medication error with harm_____

26. Harm/trauma suffered in hospital-suicide or self-injury_____

27. Fall - appropriate assessment/services_____

28. Seizure addressed/treated_____

29. Loss of consciousness addressed/treated_____

30. Other serious injury or complication addressed_____

31. Restraints appropriate use _____

32. Restraint-physical or mechanical safe_____

33. Inappropriate use of seclusion_____

34. Seclusion appropriate_____

35. ECT appropriate_____

36. ECT safe_____

37. Discharge planning appropriate_____38. *All deaths in the psych unit require PR

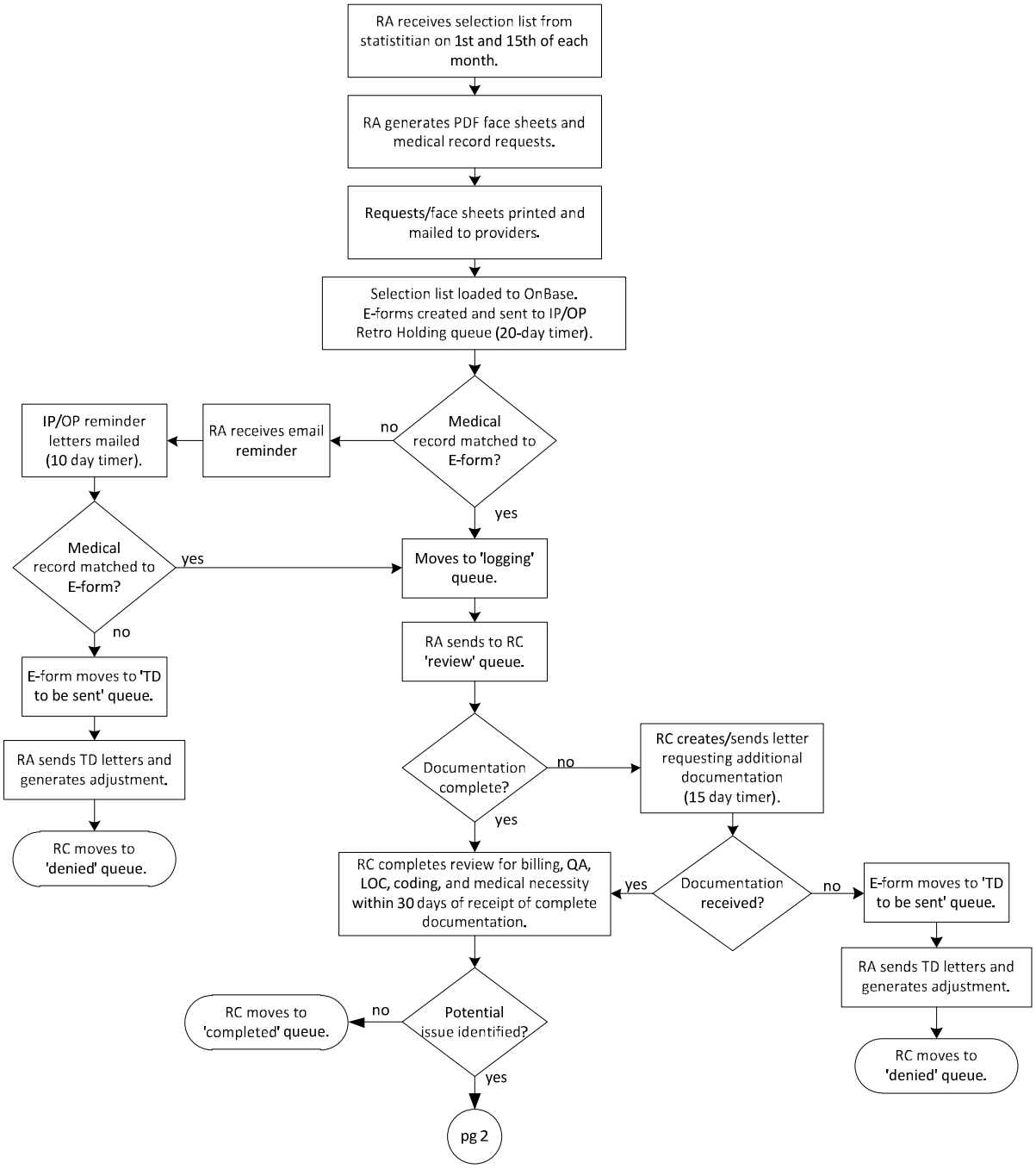
RFP Reference:
6.2.1.2

Interfaces:
N/A

Attachments:
N/A

Attachment A

Acute Retrospective Review Process



Attachment B

Acute Retrospective Review Process (continued)